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**Legislative Assembly
of Ontario**

First Session, 35th Parliament

**Official Report
of Debates
(Hansard)**

Thursday 22 August 1991

**Standing committee on
social development**

Regulated Health
Professions Act, 1991
and companion legislation



**Assemblée législative
de l'Ontario**

Première session, 35^e législature

**Journal
des débats
(Hansard)**

Le jeudi 22 août 1991

**Comité permanent des
affaires sociales**

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent

Chair: Elinor Caplan
Clerk: Lynn Mellor

Présidente : Elinor Caplan
Greffière : Lynn Mellor

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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Thursday 22 August 1991

The committee met at 0903 at the Sheraton Armouries Hotel, London.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

ONTARIO SOCIETY OF CLINICAL PERFUSION

The Chair: Good morning. The standing committee on social development is now in session. I would like to welcome everyone and call our first presentation, from the Ontario Society of Clinical Perfusion. You have 20 minutes for your presentation. We ask that you begin by introducing yourself to the committee. If you will, please leave a few minutes at the end in case any of the members have some questions for you.

Mr Henderson: Good morning, ladies and gentlemen. My name is Mark Henderson. I am a clinical perfusionist at University Hospital and I am also the president of the Ontario Society of Clinical Perfusion. Reading the agenda, I am sure you must wonder what a clinical perfusionist is.

Mr Beer: It has been the key question all week.

Mr Michlash: We have been waiting for this.

Mr Henderson: Most people, even when I explain it to them, their answer is, "Oh, yeah."

A clinical perfusionist is an allied health professional who operates a heart/lung machine during cardiac surgery. To facilitate surgery on the heart and the great vessels, the function of the heart must be arrested. You can imagine trying to sew something that was pumping. It is relatively difficult. Therefore, the functions of the heart and the lungs are mechanically and chemically arrested. Our job is to run the circulation equipment that bypasses the heart and lung functions and circulates blood through the body.

The patient's life is totally dependent on the adequacy and the correctness of the cardiopulmonary support provided. Therefore, the clinical perfusionist must achieve a high degree of discretion and judgement to ensure everything goes well.

As an analogy, I have listed the cardiac surgeon being the pilot of a large aircraft, the cardiac anaesthetist being the navigator or flight engineer and the perfusionist being the ground controller. All three of them have a very important job yet all three are totally related and totally interdependent on each other.

In Ontario, the Michener Institute for Applied Health Sciences is the only place where cardiovascular perfusionists are trained. This is a post-graduate program and it requires previous health discipline experience. For instance, I was a respiratory therapist. Many are nurses. We have some who are doctors from other countries who are not licensed in Canada. There are people who have various degrees in research and applied critical care backgrounds.

The Canadian Society of Clinical Perfusion, our national body, offers a certification process whereby clinical competency is judged and certified. The process was developed with the Canadian society as well as the Canadian Society of Cardiovascular and Thoracic Surgeons, the Canadian Cardiovascular Society and the Canadian Anaesthetists' Society. What has been done is that graduates from the school, after a limited time, take a certification exam made up by these four bodies. The professional interests in Ontario, as you can see, are represented by the Ontario society and, nationally, by the Canadian society. The Ontario society is in itself a region of the national group.

There are certain concerns that I bring to you today. Where do the perfusionists fit into this new bill and what assurances do the public have that they will receive adequate care from a qualified perfusionist in Ontario?

We are a very small group. There are 50 of us in Ontario, approximately 150 in Canada. In the United States there are very many more because of the large number of hospitals that do cardiac surgery. There are large companies of perfusionists in the US. One perfusion company does over 10,000 cases a year. They have their own Lear jets and buses. They can do cardiovascular surgery on the roadside if they wish.

We are concerned that a small group such as ours in Ontario will be lost within a large bill such as this. We are trying to maintain our identity. The main reason is that it is very easy for another profession to come in, say it could do our job and not do it adequately. The public would suffer. We are concerned that there is a mechanism available to ensure that only Canadian-certified perfusionists are employed in the province to perform recognized tasks and be protected from imported staff with questionable credentials, as has happened in the past. Any imported staff may come from other countries, as it has, or may come from within our own country.

I was wondering if you could address these concerns that we have and hopefully shed some light on them.

Mr Owens: Where do you see yourselves fitting in in terms of where you would like to be regulated? Would you like to be regulated as a group unto yourselves, or do you see yourselves fitting in as a tagalong, say, with physicians or something like that?

Mr Henderson: I think it would be very difficult for us to tag along with another group, to be put as a subsection as

another group, because our job is so unique from any other profession we have come across. We would very much like to see ourselves as a unique group within this.

Mr Owens: So you would see yourselves as having the availability of numbers to have your college and the various committees that would be required under self-regulation?

Mr Henderson: I think that would be very difficult for us to do yet. At the same time, we are fairly adamant that to be put under another group would only cause our profession to be diluted and the patient to be put at somewhat of a risk.

Mr Owens: So then you might see yourselves, rather than being added into the bill itself through regulation, having the various standards of practice of your profession set out?

Mr Henderson: Yes, we have our own standards of practice that are set up on the national level. The provincial society has adopted those as well. We would like to see those recognized if we could.

0910

Mr Beer: In regard to the questions you have asked us, it might be helpful for the witness, in terms of how they would in fact be regulated with this act were it to come into play the way it is—I realize the parliamentary assistant is not here—if we could direct that to staff in terms of how that would work out.

The Chair: With the wish of the committee, I will ask the ministry official, Mr Burrows, to respond to the questions that have been raised.

Mr Burrows: Would you mind repeating the question?

Mr Beer: The essential one, I think, would be, where do you fit in with the legislation that is going forward and, I suppose, how in fact are you then regulated or how do you proceed with your work? I think that has been a question for a number of groups which do not have a specific act. It would be useful to have that on the record.

Mr Burrows: The process that led up to the legislation was the Health Professions Legislation Review. I am not familiar with whether your group was a participant in the review. I do not recall that it was. That being the case, there is an advisory council to be established by this legislation which would be independent of the bureaucracy and independent of the health professions. It would in a way carry on with statutory authority the kind of work the review did. It would look at who should continue to be regulated, whether new groups are emerging, new technologies that the public needs protection from because they are potentially harmful and, in essence, any issue related to professional regulation.

The thought is that as a result of this legislation, that advisory council to the Minister of Health would exist. They would look at any submissions that were made, or anything that was recommended by the minister, applying criteria. Probably to start with, they would use criteria, if not the same, at least similar to those used by the review to deal with those very same questions.

In terms of regulation, though, there are other forms of regulation. One of the criteria of the review is, is the group

effectively regulated in some other way? For example, if you practise primarily in the hospital setting, then clearly there would be provisions in the Public Hospitals Act to govern the activities of health professionals working in that setting. That is a question you would have to address.

Of course, we have many professionals who are regulated in other ways but who are self-regulating too. Then they look at criteria such as numbers; for example, are you able to finance self-governance? Those things are all questions that would have to be addressed. Certainly my branch of the Ministry of Health would be happy to work with you and answer any questions you have, if you want to get ready for that process when the time comes.

Mr Beer: Just in closing that off, I think the fact that because within the legislation is the creation of the advisory council expressly there, for newer groups, as was mentioned, or perhaps ones that we as laypeople are not as familiar with, there is an ongoing process in terms of looking at how they ought to be regulated. That is probably the most effective course for your organization to take once the legislation is in place.

The Chair: There was one other question that was raised by the deputant. With the permission of the committee, I would just put it on the record. You raised the issue of immigration to this province. Do you want to ask the question, Ms Haeck?

Ms Haeck: Yes, I do. I had occasion since I have been elected to meet with someone who had in fact, as a Canadian, taken a course in a United States college and then had to deal with the Canadian regulatory body. In this case, it was also a respiratory technotherapist and she fell under the regulation of that body. As the organization that would be ultimately regulating whoever enters your profession, would you not see that as a safeguard in dealing with whoever might be emigrating from the US or some other country?

Mr Henderson: Currently there is no reciprocity between the Canadian certification standard and the American certification standard. Officially they are both recognized across the borders as being in place. I think there are only minor safeguards available right now for having people come into the country, practising perfusion in Canada and in Ontario, people who are questionable credentialed. It has happened in the past.

Ms Haeck: As far as employers are concerned, obviously when they are advertising for this particular job, there are certain credentials or criteria, education background that they are looking for. Is it considered basically a reciprocal arrangement, with the qualifications of the individual coming from the United States bearing the same weight with the employer as yours? Or is this in fact an area where your organization can work with the hospitals, through the doctors performing this type of surgery, to impact on the hospitals to say our educational qualifications are such that we should be limiting who is employed from other countries?

Mr Henderson: The Ontario society has contacted the Ontario Hospital Association and made recommendation to its members that they only hire Canadian-certified perfusionists to work in Ontario, so that the Ontario society,

our group, would have some means of recognizing the credentialling these people have. There was a big concern some time ago in Toronto when a large group came from the United States to fill a large void in the employment. They said it was not their mandate to do this, and that they would not make that recommendation to the hospitals.

We have asked our members to take it back to their own hospitals and make those recommendations. However, we are getting mixed response from individual hospitals.

Ms Haeck: I did have one more question, which follows on some of the comments Mr Burrows made.

The Chair: I have a question from Mr Hope.

Ms Haeck: Okay, that is fine, thank you.

Mr Hope: I understand, through the study, you are involved in the consultation process because of the new technology. Do you see a growing need in the profession as the technology improves? Will you see changes in your job as technology improves?

Mr Henderson: Over the past few years it has changed quite a bit. I have been a perfusionist for just under 10 years now, and we have changed quite a bit as the technology is making leaps and bounds. As you know, as the need for cardiac surgery increases, so does the need for a perfusionist and so does the need for increasing technology.

We have hit somewhat of a plateau as far as technology goes, only because we are limited to the equipment that is available to us. However, the applications of the equipment now are progressing ahead. The patients that we see are progressively getting older and sicker, and we are able to be very successful in taking care of these patients. I think the need for perfusionists will grow as the need for cardiac surgery grows.

Mr Hope: To follow up on that, as the technology changes and so do the requirements change, I have to propose a question dealing with the general public, as to how the quality assurance is there to the individuals.

Mr Henderson: That is what we are concerned about. Being a relatively small group, we have taken it upon ourselves, through the education and certification process, to ensure that the quality is there from graduation of the students.

We work with the CMA in the accreditation of all clinical training sites and through our recommendations; we recommend that the people be certified before the hospitals employ them. Right now we are at that stagnant point of trying to get the hospitals to agree to follow our guidelines.

The Chair: There are a couple of minutes left. I would like to ask a question. Do you know of any profession practising in Ontario today that has a mandatory, on-going, continuing education requirement for maintenance of its certification?

Mr Henderson: Not to my knowledge. I know that perfusionists have an ongoing maintenance of certification. There are certain criteria that a perfusionist must maintain in Ontario and in Canada to maintain certification.

The Chair: To maintain certification by whom? Who does the testing?

Mr Henderson: The Canadian Society of Clinical Perfusion.

The Chair: Do you have a relicensure every so often, where you have to prove that you have maintained your credentialling?

Mr Henderson: Every two years.

The Chair: But there is no college that enforces that.

Mr Henderson: No, we do not as yet have a college.

The Chair: The comment I wanted to make was to just inform you of the report on access to trades and professions. I thought it might be helpful if you made yourself aware of that, and also became aware of immigration policy in the country, which has effect—attracting where there are labour shortages and so forth—as well as the fact that there are no interprovincial mobility barriers for labour in Canada. Generally it is the employer that sets standards of and criteria for hiring, for job requirements. I just thought you might want that information on the record. You could then look through those documents, and if there are any additional questions that you have, I would encourage you to meet with ministry officials.

Ms Haeck: May I just quickly ask the one question I had left, which was how many actually are working in the field? As far as your being able to sustain yourselves and follow all of the requirements of this act as a self-regulating profession, you do need some numbers and financial resources to maintain about six committees. How many people are working in that field?

Mr Henderson: That is the big stumbling block for us now. There are approximately 50 in Ontario and about 150 in Canada.

Ms Haeck: I see. It is a small group.

Mr Henderson: Yes.

Ms Haeck: It is very essential, but it is a small group.

The Chair: Thank you very much. We appreciate your presentation today.

0920

CHINESE MEDICINE AND ACUPUNCTURE ASSOCIATION OF CANADA

The Chair: I would like to call next the Chinese Medicine and Acupuncture Association of Canada.

Dr Cheung: Good morning, Madam Chair, members of the standing committee and ladies and gentlemen of the audience. I am thankful for this opportunity to address this committee regarding the prohibitions of Bill 43 and the subsequent exempt status of Chinese medicine and acupuncture. It is also my intention to convey the urgent need for the legislative regulation of this profession.

Chinese medicine and acupuncture was first introduced into Canada in the late 1800s by the early Chinese immigrants. Over the years, this form of health care has become exceedingly popular as a result of the holistic trend towards health care when conventional western medicine has failed to meet the needs of health care consumers.

Attempts for regulation of this profession have been made to the past governments of Ontario. It is our hope that legislative recognition by the government of Ontario

of Chinese medicine and acupuncture as a separate and distinct profession will ensure the following: (a) to enable health care consumers seeking Chinese medicine and acupuncture treatment to be attended to by a qualified practitioner of Chinese medicine and acupuncture; (b) to make provisions to provide medical insurance coverage for health care consumers who require acupuncture therapy; (c) to assist in reducing the current health care budgetary deficit.

In terms of the qualifications for the practitioner of Chinese medicine and acupuncture, I would like to direct your attention first to the videotape.

The acupuncture inserted here on the human subject—as you see, the needle in the back of the head, in the back of the skull, is as deep as one and a half inches there. If it is inserted too deep, it can injure the medulla oblongata and cause death. The needle on the shoulder there, if it goes too deep, can puncture the lung and cause pneumothorax. The needle on the back there is corresponding to the kidney location. If it goes too deep, it can puncture the kidney.

On the ear acupuncture there, although the needle is a lot smaller and shorter, proper insertion and manipulation still have to be stressed. If not and if the cartilage of the ear is injured, that can cause inflammation and, as a result, the patient may lose the ear. That has happened in China when it was practised by unqualified practitioners. The patient's ear cartilage was inflamed, and as a result she lost the ear. In taking out the needle beside the eyeball, that also went as deep as one and a half inches.

This review simply indicates that any practitioner performing acupuncture has to be well trained and qualified and competent to do it. It is not a matter of 30 hours of training, then you can go into a hospital or any clinic facility to treat patients. Of course, without doing it properly, that can also influence the effectiveness of acupuncture. It is very important. It is not just inserting needles there. There is a lot behind it.

Basically now in Ontario, there are three groups of people practising acupuncture. The first group would be the members of my organization; 70% of them are from mainland China and the 30% come from the other parts of Canada and other countries. Of course they are very qualified, and there are strict criteria of selection of the membership.

The second group would be licensed medical doctors, chiropractors and physiotherapists. They may be qualified in practising their own disciplines but may not necessarily be competent in practising Chinese medicine and acupuncture. There is an organization in Ontario that is being used to train licensed medical doctors and physiotherapists for 30 hours, and then they let them practise on their patients. Now they may increase the number of hours to 100. Still, it is not sufficient. With that kind of deficiency in their training, the patient recovery would be prolonged. That will in turn increase the health care costs.

0930

The third group of people would be individuals who have no basic medical training at all, but they go a country like Sri Lanka for four to six weeks and come back with a certificate or degree and post themselves as qualified acupuncturists. There are many of them doing it in Ontario. In London alone, from what I know, there are at least 20 of

them already with a certificate from another country practising and posing as qualified acupuncturists in London.

It is of great concern to my organization that the exempt status of acupuncture will allow these individuals, who have no basic medical training and only a four to six week course of study, to cause great danger to the public. Our intention is that the Western medicine doctor and the Chinese medicine doctor must work together in harmony to provide the best possible care for the people of Ontario. Therefore, legislative recognition is the best means of achieving this goal.

In China a doctor of Chinese medicine and a doctor of Western medicine have equal footing. In the state of Nevada a doctor of acupuncture, a doctor of herbal medicine, a doctor of traditional oriental medicine has a degree given by the state of Nevada government. That takes four years of study besides two years of university. In the state of California the same number of years is also required.

I do not want to go into further detail about the economics of Chinese medicine acupuncture. I would like to stress though, utilizing Chinese medicine acupuncture in the health care system of Ontario will in the long term reduce health care costs of Ontario.

Due to the unregulated nature of this profession, patients are subject to paying the GST for health care. My organization is of the opinion that health care should be GST-exempt. It is most unjust and certainly lacking compassion and humanitarian concern by the government of Ontario for health care consumers.

My organization has seven chapters across seven provinces in Canada. I am the national president of CMAAC. My organization is also a member society of the World Federation of Acupuncture Moxibustion Societies. The headquarters is Beijing. WFAS, which is short for the World Federation of Acupuncture Moxibustion Societies is also fully recognized by the World Health Organization and works in very close collaboration with WHO to promote Chinese medicine acupuncture around the world and to benefit all of mankind by the year 2000.

In closing, we strongly feel that the protection and the best interests of the general public in regard to health care must be an urgent priority of the government of Ontario. By incorporating Chinese medicine and acupuncture into the existing health care system, the current health care budgetary deficit can be minimized in the long term; there are already precedents in other countries like the United States, England or France. By minimizing health care costs, this in turn will decrease the tax burden on the general public. Also, it is CMAAC's hope that this proposal will assist in making the health care system in Canada more efficient and that WHO's goal for all by the year 2000 will be realized.

Mr Johnson: Thank you, Dr Cheung, for your presentation. I found it most interesting and certainly I have had a long interest in the medicine of acupuncture. I see that you are a doctor and that, I guess, would mean that you are a medical doctor as well.

Dr Cheung: I am a medical doctor in China, but I am not a licensed MD here.

Mr Johnson: You are not a licensed MD here?

Dr Cheung: No, but I have training in both disciplines.

Mr Johnson: I was curious. I saw those needles being inserted into the body and they go quite deep. You indicated that if they were not done exactly correctly, serious consequences could result. I am curious to know, have there ever been, in Ontario, any lawsuits or litigation as a result of improperly practised acupuncture medicine?

Dr Cheung: Fortunately there is nobody yet seriously harmed. In my practice, in my clinic, I have received quite a number of patients that have not been treated properly and have also developed some side effects like abdominal pain or swelling of the leg due to the improper insertion of a needle.

But I would like to point out we should not wait until something serious happens. This is common sense. When you are taking a needle and inserting it into a human body, if it is not done properly by a competent practitioner, danger can ensue automatically. I do not want to wait until some death occurs before your government does something.

Mr J. Wilson: Thank you, Dr Cheung, for your excellent presentation. You raised a number of very good points. On the basis of your presentation, it does appear to make sense that it should be regulated for the protection of the public and for the profession itself. I was just wondering, did you appear before the Health Professions Review Legislation? Subsequent to that, why was acupuncture and Chinese medicine not recommended for regulation at that time? Are you aware of reasons given by government?

Dr Cheung: I delegated my colleagues to appear before the Health Professions Legislation Review. At that time, in my recollection, the government believed acupuncture did not pose any risks of great danger to the general public. Therefore, they did not regulate it. That was the decision they took at that time.

Mr J. Wilson: So it did not fit one of the criteria set out by the committee.

Dr Cheung: That is right.

Mr J. Wilson: Secondly though, if I may, Dr Cheung raises a very good point about controlled acts and that acupuncture does involve the insertion of needles below the dermis. Perhaps we could have a clarification of that for the record. I just want to make sure they are able to carry on the practice of acupuncture and are not in any way impeded by this legislation. Perhaps we could have a clarification from counsel on that.

Mr Burrows: The previous government and the current government have both confirmed, on introduction of the legislation, that there would be a specific exemption by regulation for acupuncture, ear-piercing and a number of other invasive procedures.

The rationale for not including acupuncture as a self-governing profession was based on essentially two things: There was not a proven risk of harm other than possibly the transmission of disease. It is anticipated there would be a supplementary amendment to another piece of legislation dealing with public health to ensure sanitary procedures were followed, because there are two reported instances of

transmission of AIDS in the United States, so it is the ministry's intention to introduce complementary amendments in another piece of legislation to ensure that occurs. The other criterion that was not met was the regulation of a person's doing this activity. Quite a number of the practitioners in this province in fact are already members of other regulated professions, for example, naturopathy, chiropractic and even medicine.

0940

Mr Beer: How many members do you have in the Canadian organization?

Dr Cheung: In my organization we have close to 600 members across Canada. In Ontario alone we have approximately 250.

Mr Beer: You outline in your brief the three different groups that might be practising acupuncture. In group two, which you noted was composed of licensed medical doctors, chiropractors and physiotherapists, how many would be practising acupuncture on a regular basis?

Dr Cheung: I think quite a number of that group are practising acupuncture. Many family doctors, chiropractors and physiotherapists do. If you add them up it will come to a big number. The idea is they may not pose great danger to the general public, but they will lengthen a patient's recovery period and that will increase the costs. To practise acupuncture is not so simple, as I indicated earlier, as just inserting the needle. There is certain training. That is why in China it takes six years to be a doctor in Chinese medicine. In London, we have a school. We also take six years. To get into school or my organization, applicants have to have two years' university. Then it is four years' intensive training.

The Chair: Thank you very much for your presentation this morning. If there is any additional information you think would be helpful to the committee, you can submit briefs in writing through our clerk at any time and also, as mentioned before, this legislation suggests there will be an advisory council available for your organization to take the matter further.

Dr Cheung: Thank you, members of the committee.

HEALTH CARE AIDE ASSOCIATION OF ONTARIO

The Chair: I call the Health Care Aide Association of Ontario. I would ask that you come forward. Begin your presentation by introducing yourselves to the committee. You have 20 minutes for your presentation and we ask you to leave a few minutes at the end of your formal presentation in case members have any questions to ask. Thank you very much. Please come forward, have a seat before the microphones and begin your presentation now.

Ms Robbins: Good morning. I am Mona Robbins, health care aide, president of the Health Care Aide Association of Ontario. With me are Sheryl Stephens, health care aide, and Doreen Smith, health care aide, who is on the education committee for the association.

In the last few years, my colleagues and I have become increasingly aware of the necessity to have an organization exclusively concerned with the problems and needs of the

certified health care aide and the chronically ill. We are here today to speak for the most vulnerable patient in our society. We are here to ask that we guard against the exploitation of the chronically ill, disabled and the elderly.

With this evolution of change in the health care system today, the elderly and the disabled will remain in their homes longer. We agree that beds in hospitals should be left open for acute cases; we agree that the elderly and the disabled should be kept from behind bricks and stones, but we must also agree that the resident who will be admitted to the long-term care facilities will be heavier care and chronic care.

I have enclosed a recent London Free Press newspaper clipping about a couple who hired a person who was hitchhiking; they picked him up as a hitchhiker and hired him supposedly as a health care aide and they scalded a patient to death in the bathtub. In this paper it says here, "Evidence showed most of the home's health care aides were unskilled labourers."

Daily we read in the newspaper of harm, neglect, sexual abuse, physical abuse, not to mention verbal abuse, that is inflicted on the most helpless, the elderly and the chronically ill. We should not leave it to the employer who is in business for profit, or nursing home inspectors. In nursing homes, homes for the aged, retirement homes and the community, it should be made mandatory to take advantage of hiring trained, qualified, certified health care aides. This could be an added deterrent in keeping such tragedies from occurring.

It is everyone's concern to protect our ever-increasing population of elderly and chronically ill and to see that they are provided with proper and qualified care. The definition of quality care is caring for both body and mind and it is directly related to the knowledge and resources a person possesses, thus enhancing the quality of life.

The unqualified worker has no place on the job. They jeopardize health and safety to the residents and also to the staff. You cannot learn intensive bedside nursing in two days of orientation. You cannot learn and be aware how important it is to use safety devices or good observation skills and how important it is to communicate these observations. Good observation skills can save and have saved lives of the helpless and safety can save broken limbs or fractured hips. In two days you cannot learn feeding techniques to prevent choking and aspiration. The list goes on.

We must also keep an open mind, not just including our locality but across the province. In a small community it is different. There we know each other's families, but in large cities you do not get to know or see the family. Some long-term care facilities only hire young high school students and part-time staff. This creates a large staff turnover which creates an undesirable environment and lack of consistency.

The newly formed Chartered Health Care Association of Ontario seeks recognition and acceptance for its members for the specialized nursing they perform. We are a large group of people working in the medical field, and certified health care aides are primarily responsible for providing hands-on intensive bedside nursing care in long-term care facilities.

Certified health care aides are in the community; certified health care aides hold positions such as administrators

of retirement homes and certified health care aides hold licences to manage facilities to care for patients for the transition from hospital to home. Also, certified health care aides hold positions in doctors' offices. We too are concerned and responsible for the person in our care. Since the consumer is the most important person in nursing homes, homes for the aged, retirement homes and the community, we seek to gain his or her trust in our competence and our ability. We do not want to allow the reputation of the certified health care aide to be undermined by being mistaken for NAs, nurses' aides, since this would reflect back on the bedside care giver.

0950

It is also the certified health care aide who is the link and who works closely with other members of the health care teams, such as physiotherapists, registered nurses and doctors. We do more than dress, feed, toilet, wash and stick our patients in a wheelchair. We understand the process of aging, the terminally ill, the psychological aspect of giving up.

Our work involves taking vitals; observing mental, social, physical changes and recording these; active and passive physiotherapy exercises; repositioning to prevent pressure sores and contractures; collecting specimens and other nursing things in the scope of practice; assisting to develop nursing care plans; participating in team conferences, and palliative care for the dying. We are trained to work at the bedside; we are the front-liners.

Remember, when a patient who in many cases is helpless calls out "Nurse," it is the health care aide who answers. To the resident, whether health care aide, registered nurse, registered nursing assistant, certified health care aide, we all look alike. A nurse is a nurse. We are bedside specialists in times when nursing is getting farther away from the bedside. Many chronically ill have no one to speak for them; they have no family. They are alone, they put their trust in the care giver.

One of our objectives is to maintain the high standards and ideals of the certified health care aide. The workload and heavier care and more complex care is steadily increasing. We care for people with Alzheimer's disease, multiple sclerosis and other debilitating diseases. We must have the knowledge to keep pace with the changing needs and ensure the highest quality of care. We also need to see the level of preparation upgraded. We need to update and improve the certified health care aide program. Also, the certified health care aide in the community will need to be more knowledgeable. We need more certified health care aides, as we are always working short-staffed. We are making an appeal that the \$647 million aimed at the elderly and disabled will be towards more staffing in the long-term care facilities.

We would like to see improved education and a right to legally practise more of what the certified health care aides are taught in health facilities. For example, health care aides cannot take a person's blood pressure, so the teaching system has been changed to reflect that. However, many establishments will teach the procedure once the worker is under their supervision. Many health care aides feel the procedure should be inclusive in their duties because blood pressure

s an important vital sign. Many establishments feel that certified health care aides are competent and, when the workload is heavy, will designate treatments and blood pressures.

At this time the health care aide course is offered at community colleges, secondary schools and as a two-week professional development program. We are a large group of people working in the medical field without provincial standardization of course tests or disciplinary action of negligent members. We wish to establish standards instead of guidelines. Our goal is to have the curriculum content of all health care aide programs basically the same and to have standardized provincial exams for all students. Standards would provide guidance for certified health care aides, educators and employers.

We seek to promote nursing excellence and quality nursing care. We would like classroom training to teach principles and procedures of practical work and training in cleanliness and efficiency. There should be practice in demonstration rooms before being allowed to care for people. Nurses' aides should not be allowed to be hired right off the street, having just worked in factories with no medical knowledge whatsoever. We would like to see all health care aides graduate from an accredited college health care aide course.

We are utilized by being called upon to do non-nursing things such as laundry. On the other hand, when workload is heavy, we are designated duties such as vitals and treatments. Also, this is a high risk for potential infection spread, handling contaminated laundry and then caring for the patient.

We would like to be registered with the health professions legislation disciplinary act. This would give us licensing as a professional and competent person. We would be assured of our competence and of the competence of our colleagues. Under the legislation health care aides could be monitored. We would also like to establish a disciplinary committee to deal with harm, neglect, physical and verbal abuse. It is a sad situation, but we need to protect the public by investigating complaints about nursing practice and professional misconduct or incompetence of its members. A prevention method used for disciplinary purposes would result in better nursing care.

Because patients and the public are the most important people in the reform of Ontario's long-term care service and our first consideration, the association would like to establish maximum protection to the public. We feel there should be a standard-of-care clause established as well as a scope-of-practice clause. We would like to be registered with the Regulated Health Professions Act and wish to gain its support as we feel all these things would fall into place.

A summary of what the association would like to establish: licensing through registration; provincial exam; a disciplinary committee; improved education in chronic gerontological nursing; a right to practise more of what a health care aide is taught; to promote close relations in the provision of health services and help create an environment in which health professions can work together co-operatively and effectively, and high standards and ideals.

On the last page of my summary I would like to bring to your attention that the Nursing Homes Act states health

care aides give only personal care, for example, dressing and grooming. Health care aides do more. Health care aides give the scope of practice that is in the Nursing Act.

The health care aide is the practical nurse and gives all hands-on bedside nursing in chronic and geriatric long-term facilities. We promote health and recovery and relieve pain by reporting it to the medication nurse. Health care aides meet basic physical, supportive, preventive, therapeutic, palliative and rehabilitative needs in order to attain and maintain normal function. Health care aides observe, report and communicate changes in residents' physical or emotional status. The physiotherapist often only comes in twice weekly. Health care aides continue physiotherapy when the physiotherapist is not available. We are called upon to assess and give input in nursing care plans. We have a legal responsibility to the person in our care.

I also would like to bring to your attention that the Nursing Act states that it is a nursing act performing invasive instrumentation, including manual and digital instrumentation beyond the anal verge. Health care aides take rectal temps, glove, and administer enemas and suppositories and more.

The Nursing Homes Act states that laundry, etc, does not count for nursing hours. Example, there are 107 patients to six health care aides on a shift. That leaves five health care aides for 107 patients, as one health care aide is down in the laundry most of the shift, which takes away from nursing hours. We would like to see all six in nursing care. Also, cross-contamination becomes frequent.

Health care aides also hold administrative positions such as administrator of rest homes, making important decisions daily such as setting standards to ensure quality care and efficiency within the establishment. Four ministries developed the health care aide program. We would like to see the health care aide role be reassessed and redefined and serious attempts made to raise the health care aide nurses' standards and to encourage a better class of recruits.

We look forward to your participation in the planning for the future role of our profession. Thank you.

The Chair: Thank you for an excellent presentation. You did not look nervous at all.

Mrs Cunningham: I would very much like to thank you for being here today and for all the work you have done in the past, especially in the last couple of years as you have gotten your organization together and worked hard to do that. What is your membership now within your own organization?

Ms Robbins: We are just starting out and that is our problem. We are trying to do everything and we only have about 400 members so far, but we have chapters in Sault Ste Marie, Ottawa, Oshawa and London.

Mrs Cunningham: That is great. I am certain you will have a lot more members. When you say only 400, that is a lot to this committee.

Mr Hope: You raised a number of good points, such as accreditation by community colleges. I know currently that community colleges have health care aide systems in place which require a certain standard. I can speak of that

because I know the in-depth basis of the education that takes place.

When you make mention of the long-term care reform and long-term care facilities and home-based service, would that not be more the responsibility, as we see in rest homes and private enterprise, where they are the ones who are hiring the non-registered, the nurses' aides, versus the community-based ones who are hiring qualified people? Is that not the case as to what is happening?

Ms Robbins: No. They are hiring people right off the street, right from factories. That is why we are asking, please do not leave it to the employers any longer. The health care would like to see all qualified people hired, and this is one way we could monitor that.

The Chair: We appreciate your coming before the committee this morning. If at any time there is anything else that you think would be helpful for the committee during our deliberations, please feel free to communicate with us in writing through our clerk.

1000

ONTARIO OSTEOPATHIC ASSOCIATION

The Chair: Next is Douglas Lauder of the Ontario Osteopathic Association. Are you here representing the association or are you here as an individual?

Dr Lauder: I am past president of the Ontario Osteopathic Association and I am representing that association. Mine is a short presentation, as you can see.

In recent years, the terms "osteopath" and "osteopathy" have been replaced by the terms "osteopathic physician" and "osteopathic medicine." The enclosed photograph of my licence to practise, a government of Ontario certificate, uses the term "osteopathic medicine," and this document is dated April 25, 1955. These newer terms are seen to be well established over time.

The osteopathic profession recommends that in Bill 55, An Act respecting the regulation of the Profession of Medicine, subsections 16(1) and 16(3), the word "osteopath" be changed to the term "osteopathic physician." That is my recommendation.

Mr Beer: We have had a number of questions around titles, and I think as laypeople, it helps us to understand better why these terms have evolved or what it is that is trying to be expressed here. Is it simply that this is the way in which your profession is referred to and that is the language you want, or does that term "osteopathic physician" say something more, say something else besides the meaning of the terms that are in there, where it says "osteopathic physician or surgeon"? I wonder if you could just help us with that.

Dr Lauder: The term "osteopathic physician" probably takes the connotation away from a separate profession and into the general medical profession. This is the case in every jurisdiction in the United States, for example, where every state recognizes osteopathic medicine fully and completely, the same as a medical physician. This also has taken place in the province of Alberta and in the province of Quebec, except that of course in Quebec there is a language

problem. The examination has to be written in French and we do not have anybody who can do that.

These are situations that have taken place and I think that perhaps explains why we prefer the terms "osteopathic medicine" and "osteopathic physician" rather than "osteopath" and "osteopathy."

Mr Beer: Could I then ask, through the parliamentary assistant, did the review consider using this term, and if so was there any specific reason why they decided to use the terminology that is currently in Bill 55, subsections 16(1) and 16(3)?

Dr Lauder: Those were the original terms years ago, but they really have been replaced by the ones that I have requested.

Mr Burrows: Not having been part of the review on this issue, I honestly do not know what the review considered. However, I can say that the review concluded there was no need to protect "medicine," but the title of "physician" would be protected to members of the College of Physicians and Surgeons of Ontario.

I would point out that the profession of osteopathy, it is envisioned, would be governed, along with physicians and surgeons, by the College of Physicians and Surgeons of Ontario. The review envisioned that there would be a special register for osteopathic practitioners. Really, the recommendations stopped at that point. It is envisioned that in the writing of regulations, issues between the governance of orthodox North American medicine and osteopathic practitioners would be worked out between representatives of the two professions. A great deal of detail has yet to be done in that area.

The Chair: We appreciate your presentation before the committee. If there is anything that you think might be helpful over the course of our deliberations, please continue to communicate with the committee in writing.

LEN BOKSMAN
VIKKI PAQUETTE

The Chair: I would like to call next Len Boksmán and Vikki Paquette. You have 10 minutes for your presentation. We would ask if you would leave a few minutes at the end in case members have any questions.

Dr Boksmán: I am Dr Len Boksmán. As a 1972 graduate of the University of Western Ontario, I am currently in private practice in general dentistry in London, Ontario. I am also a part-time faculty member in the faculty of dentistry at the University of Western Ontario. I have authored and co-authored over 50 scientific papers and a text on dental techniques.

I am here today with Mrs Vikki Paquette, a valued member of my health care team whom I will introduce to you shortly. We welcome this opportunity to address your committee, not as representatives of a special interest group, but simply as health care practitioners who are concerned for the wellbeing of our patients.

In this regard, we have some very specific concerns regarding Bill 47 as it is currently drafted. Under section 3, the scope of practice states, "The practice of dental hygiene is the assessment of teeth and adjacent tissues and

treatment by preventive and therapeutic means." It goes on to state that the provision of restorative and orthodontic procedures and services is on the order of a dentist. This latter portion is consistent with section 4, which lists the authorized acts.

Our concern arises from the fact that the part just previously quoted, namely, "treatment by preventive and therapeutic means," is not on the order of a dentist and is therefore not consistent with the authorized acts as described. In fact, it would imply independent practice by hygienists. It is our strongly held belief that this would result in serious shortcomings to the wellbeing of the public and should therefore be reconsidered.

At this time, I would like to introduce to you Mrs Vikki Paquette, a registered dental hygienist, who can elaborate on this matter. Mrs Paquette, an honours graduate of Cambrian College, has been in the field of dentistry for 16 years, 13 of those as a practising dental hygienist. During this time, she has had the experience of working with a number of dentists in several cities throughout Ontario.

1010

Mrs Paquette: I would like to begin my comments by thanking the committee for the opportunity to express our concerns. I hold what I believe to be a widely held view by my colleagues in the profession of dental hygiene, namely, that our patients are best served by a team approach to their dental needs. The team concept as currently practised creates many benefits for the patient. It ensures that the patient is seen by two professionals complementing each other's skills, which results in complete care. This type of approach also leads to in-house quality control and minimizes the risk that something vital to the patient's care might be missed. Our patients deserve to receive a diagnosis by a dentist. It is our belief that the current RHPA proposals will break the team approach to the delivery of oral health services. To us, the most effective and efficient care is achieved when the dental hygienist functions in collaboration with the dentist.

We do not believe that comprehensive oral health care can be achieved if the dental hygienist establishes practice apart from the dentist. We believe that the current proposals under the RHPA will lead to the fragmentation of patient care, and this cannot be in the best interests of the public. To quote from the past president of the Ontario Dental Hygienists Association, "Dental hygienists cannot function in a vacuum independent of dentistry nor do they want to do so."

It has been stated by some that the current legislation will allow better and more affordable care for our seniors in nursing homes. People are living longer and, with enhanced preventive care, are keeping their teeth longer as well. Surely there is a role for the hygienist in the care for the elderly. However, we cannot endorse a role which would include the provision of treatment services for any patient group without the benefit of a diagnosis. To do otherwise could place the patient at risk.

Institutionalized seniors are generally medically compromised. The complexities of their health status must be weighed carefully prior to establishing any oral health

treatment plan. Patient management of the elderly begins with a diagnosis.

Cost containment must not dictate dramatic changes to the scope of practice granted to any professional group.

This whole dilemma has a simple solution. To shift the phrase "on the order of a dentist" just prior to the phrase "treatment by preventive and therapeutic means" in the scope of practice section would serve to give my profession greater freedom compared to the current act which requires direct supervision on the part of dentists and would serve to protect the public in that the team approach would remain intact.

In summary, it is our sincere hope that this committee will review the proposed scope of practice statement for dental hygienists and bring forward amendments to ensure that dental treatment services are provided on the order of a dentist.

Mr Johnson: In your presentation, you mention some of the serious shortcomings to the wellbeing of the public that could result, in your opinion, if the changes are not made that you request. I was wondering if you could elaborate on what these serious shortcomings might be because I think that the relationship is a good relationship, but I am not sure that the workhygienists do really necessitate being seen by a dentist prior to some of the functions that occur. If you could elaborate on that, I would appreciate it.

Mrs Paquette: I would like to answer that question, if I could. I believe that there is harm to patients by, for example, an independent hygienist. The risks are very severe for the medically compromised patients. Someone with a heart murmur, history of rheumatic fever or any artificial knee, prophylactic valves, are under the risk without any pre-medication that they may run into subacute bacterial endocarditis, which can be fatal. I am not licensed to give an authorized pre-medication; therefore, the patient would have to go back and get a prescription from the doctor. It is not only that they are at risk, but it is very inconvenient.

Mr Johnson: How often would this occur?

The Chair: I have other questioners, Mr Johnson. Thank you.

Mr Beer: Just to in effect follow along in the same line of questioning, we certainly agree with your idea around the team approach, and I think that is what we have been getting from many health care practitioners. But also recognizing that we are trying to widen accessibility and choice, I think one of the issues here that you are perhaps aware of is that there have been suggestions by other dental hygienists that "on the order of a dentist" should be taken out entirely and they should have an even more independent practice. So your point of view is different and interesting.

But in following along, would it not be that the college that would be set up here in fact would be dealing with many of those concerns around the independent practice that would be permitted here? I am trying to get the balance between where we say to you and your colleagues as professionals that we would recognize that you would not do those things for which you are not properly qualified or trained. While I do not understand all of the things that

would be permitted under what is set out here, it seems to me that as we move into long-term care and we move into dealing with people in their homes, we need to develop greater flexibility, in a careful way.

Mr Beer: Why would you not see a dental hygienist being able to perform a number of those activities?

Dr Boksmann: I can take that, if you will. I think the flexibility issue is extremely important. When we are dealing with patients who are possibly at risk, our concern is that we create legislation that protects our constituents from possible harm, and in this situation there is definitely a medical risk involved which the hygienist is not trained to diagnose.

Mr J. Wilson: Just to point out that we are sympathetic to your concerns about Bill 47, section 3, and the definition in the scope of practise and will undertake to try and straighten that out during the clause-by-clause proceedings.

But I am interested, I have had dental hygienists in my own riding of Simcoe West come and certainly give me the impression that they would like to be able to practice independently, for instance, in long-term care facilities. Is that, in your opinion, very much a minority group? I know yesterday we had the Ontario hygienists' association stress the team approach, so we kind of get conflicting views.

Mrs Paquette: It is a direct quote that I did state in the presentation, just in May 1991, and I do believe that I am—

Mr J. Wilson: Adequately expressing the majority of the members.

Mrs Paquette: Yes, with my colleagues.

The Chair: Thank you very much for your presentation. We appreciate your appearing before the committee today.

1020

WILLIAM REID

The Chair: William Reid and Max Hanna. You have 10 minutes for your presentation. If you leave a few minutes at the end for questions from committee members, it would be appreciated.

Dr Reid: Before I start my presentation, I would like to mention that my colleague Max Hanna will not be speaking through the presentation but is willing to answer any questions after. Our philosophies are the same. We have gone through this, and although they are my words, we are on the same wavelength with this presentation.

My name is William Reid and I have been a dentist in east London for the past 25 years. My colleague Mr Max Hanna, a denture therapist, has been involved in dentistry for over 45 years and has practised in the same building as myself since 1975. We have collaborated during this period in providing partial dentures for the public as specified in the existing legislation and have similar feelings regarding the proposed new law. Mr Hanna also works with Dr Bruce Pellow, another dentist in the building, and Dr David Adachi in the village of Watford.

The new bill that allows denture therapists to provide partial dentures to the public independent of the dental profession is poor, retrogressive legislation. It is absolutely essential that the lawmakers and public understand that the

ultimate success of a partial denture is dependent upon the status and health of the existing teeth and supporting structures, and conversely, the integrity of the teeth depends upon a well-designed and constructed partial denture appliance. Max Hanna surely wants his partial denture to satisfy his and the patient's expectations, and I certainly want the existing teeth to not be comprised by the denture that he places.

In short, all our training and experience tell us that to provide a proper partial denture service to our patients, certain basic biomechanical criteria must be satisfied. The training provided and the scope of practice allowed by law in denturism in no way enables the therapist or denturist to do this.

For example: It is stated in the proposed legislation that an assessment of the arch is all that is required. We fail to see how this serves the needs of the public. Remember, teeth are present here and a diagnosis with a periodontal examination using a perio probe, vitality tests, necessary radiographs, X-rays and other diagnostic measures must be taken. A denture therapist just does not have the diagnostic tools, information and training that is needed to make solid judgements as to the status of the teeth and the structures that will support the partial denture.

Second, the great majority of partial dentures require rest preparations and guiding planes to satisfy well-established design principles. A denture therapist, by law, cannot cut into teeth with rotary drills to provide these essential modifications. This fact alone should give the committee pause to re-evaluate the new legislation.

Third, a denture therapist, without a total diagnosis, is unable to provide legitimate treatment options to the patient. Just because there are spaces in the arch does not automatically mean a partial denture should be placed. A bridge or even no treatment at all may be the proper direction to pursue. Many times a choice of which way to go will be made by the patient depending on finances, age, time constraints, etc, and this is good, because he or she has been given all the information needed to make alternative choices. There is new legislation that is being considered by this government that will assure patients in all health fields of the right to be totally informed as to treatment. From our point of view, Bill 50 does not allow all patients to be fully informed as to treatment alternatives, and this is definitely at odds with the other legislation.

Mr Hanna and I have been working together within the existing law for the past 15 years. I recognize his fine technical abilities and the genuine goodwill he has with our patients, and he can count on my involvement to advise and prepare the mouths of his patients so he can do the things that he has been trained for and does best.

A typical patient who presents at his office might have an old, ill-fitting upper denture and a lower dentition that is compromised but, with treatment, salvageable. He would take preliminary impressions and refer the patient to me. Following a diagnosis, I would discuss the treatment plan, alternatives and prognosis with the patient, then proceed to do any necessary dental work required, such as extractions, cleaning, restorations and oral hygiene instruction.

Meanwhile, a design for the lower partial is done, and prior to sending the patient back to Mr Hanna for construction and fitting of the new full upper denture and lower partial denture, I would cut the necessary rest preparations, providing guiding planes and make any other adjustments to the teeth that are needed. After he delivers the dentures to the patient, I examine the finished appliance in the mouth. Mr Hanna will have the patient back for any adjustments needed, and we encourage the patient to return for dental checkups to help assure the longevity of the remaining teeth. This is a typical scenario. Rarely in all the years of practising together have we encountered a case that really did not require some input from myself.

We respectfully submit this presentation to the committee to show how this team approach in regard to the delivery of partial dentures serves and protects the patient and to show our concern that removing the dentist from the process, as proposed in Bill 50, would be an astonishing retrograde step in the provision of quality dental care.

Mr J. Wilson: I think you spell out very well what the denturists want under Bill 50. They certainly claim time and time again before the committee and made a very good presentation yesterday indicating that the dental profession has not been able to provide any proof of serious harm caused by them doing partial dentures on their own. I just want to give you the opportunity to comment on that.

Dr Reid: It would surprise me that the Ontario Dental Association could not make a presentation to that area. As far as harm is concerned, I really cannot understand how a denture therapist can really determine harm. It is not within their abilities to do so. Harm, with partial dentures—supposedly an abutment tooth or a supporting tooth, when the denture is placed and the patient is happy—is 10 millimetres. How do they know two years later, when it is eight millimetres, that it is eight millimetres? There is no way or them to even do that. They do not take X-rays. They do not make measurements. The harm may be there and not forthcoming for a while.

We know from the mechanics of partial denture therapy that there are certain criteria that have to be there to make a successful partial denture. When they say harm, it is not as if the mouth is going to blow up; it is the integrity of the teeth over the rest of that patient's lifetime. It would be badly compromised.

I cannot comment on why the Ontario Dental Association has not presented anything. It may be that they do not want to take the low road and go that route, but I am sure there are instances, because we do see these instances. I know there have been presentations from private dentists to the ODA on harm that has been done.

Mr Winninger: I am told that only approximately 5% of an average dentist's work involves denture work. Do you agree with that estimate?

Dr Reid: I think that seems to be probably close to it, but maybe in my case a little more. I have been in practice a little longer.

Mr Winninger: So the suggestion that you as a profession might be just protecting your turf may be ill founded.

Dr Reid: I think it is ill founded, because we use a denture therapist. I do not covet his patients. I just want to make sure that his patients are happy and that the work is done properly.

Mr Beer: With the college that would be established by the denturists—and it is a similar question to the previous group—do you not believe that the College of Denturists would be able to set appropriate standards that the denturist, in receiving a patient, would be able to recognize, “I must refer this person to a dentist because of the nature of what I am going to be doing,” or are you saying simply the difficulty is that they will not necessarily be able to recognize potential problems in a mouth?

Dr Reid: I am saying, categorically that they will not be able to. They are just not trained. My background and legal commitment is that—as I say, I do resent the fact that if I place a partial denture and I have, let's say, not taken an X-ray and there is a cyst or something there in an abutment tooth, then I am legally responsible for that, and rightly so. I cannot see that the government could really put a poor denture therapist in jeopardy because he goes ahead and does something, the work fails and the patient wants to sue, because he just does not have the background. Max does not have the basic sciences. He does not have the medical science background that I do, and he is just unable. You would have to establish in the denture therapy course actual courses that would cover these things in the medical field. It is totally lacking now. It is not there.

The Chair: Thank you very much for your presentation. We appreciate your coming to address us. If over the course of time there is additional information that you think might be helpful, please feel free to communicate with us in writing.

1030

DENNIS LEBERT

The Chair: Dennis Lebert, you have 10 minutes for your presentation and if you would leave a few minutes for questions we would appreciate it.

Mr Lebert: Good morning. I am here today in regard to the proposed legislation that will make the prescription of a hearing aid a controlled act and what it will do to the hard-of-hearing in my area and other rural communities.

I have owned and operated the Chatham Audiometric Centre for the past five years and worked for three years with the previous owner, who had served the hearing-impaired since 1964. As a hearing instrument practitioner, I am a registered authorizer and vendor for the assistive devices program.

My office dispensed approximately 325 hearing aids in 1990, of which only approximately 43 were audiologists' prescriptions. In 1991 so far I have dispensed approximately 200 hearing aids, with 19 being audiologists' prescriptions.

These figures are fairly consistent with most rural offices. A large number of the hearing aids I authorize and dispense come from nursing homes and rest homes I service: Chatham eight, Blenheim two, Dresden two, Ridgeway one, Tilbury one, Wardsville two and Wallaceburg two, a

total of 18. This service, audiometric evaluations, case histories, fittings, counselling and repairs on site, that I provide is very beneficial to hearing-impaired residents who in many cases are unable to be transported and usually have no possible way of going to an audiologist's clinic, except by ambulance, which would be very costly and would be a misuse of the emergency service ambulances provide.

Every time a hearing aid is authorized and dispensed by myself or any hearing instrument practitioner rather than going to an audiologist's clinic the taxpayers of Ontario save \$100. With the 70,000 hearing aids that are dispensed in the province of Ontario, this figure cannot be taken lightly.

As you can see by the number of audiologists' prescriptions, a dispenser in many rural communities will not likely be able to operate if this bill becomes legislation. It will mean that the hearing-impaired consumers will have to go to larger cities to receive services.

The Association of Hearing Instrument Practitioners of Ontario had over 200 authorizers and dispensers in early 1989 and predicts that only approximately 130 will be left. Most of these 70 will be lost from the rural areas, where few audiologists exist.

How does this proposed legislation think that the current 259 audiologists will be able to give the thousands of hearing-impaired consumers the quality of care they are presently receiving with no complaints if these offices close? The rural areas in Ontario will be the hardest hit by this proposed legislation at a time when the population of 65 years and older is growing at three times the rate of the overall Canadian population. Fifty per cent to ninety per cent of these seniors suffer from some form of hearing loss.

In conclusion, this committee has the opportunity to stop this unnecessary legislation that will cause the hearing-impaired consumers in Ontario extra time, money and stress when all they want to do is obtain a hearing aid to improve the quality of life by hearing better, considering that there is no risk of harm and without waiting months for safe services that are available upon demand.

I have enclosed for your reading 11 letters I have received from different nursing homes and rest homes I do work for and, along with some clients, would have the same viewpoints as myself and my area. Thank you.

Mr Hope: Dennis, thanks for driving into London, as London is supposed to be the centre of southwestern Ontario. Dealing with the rural area, there are a couple of questions I have for you: First, where did you get your training from and from whom, and second do you serve any people under the age of 18?

Mr Lebert: My training was I attended the Sheridan College program which unfortunately has been disbanded due to some conflicts where different committees have felt that we should be doing just dispensing. So they did not want to teach testing and fitting, as I do now. When I received my training from Sheridan College I was taught by audiologists, doctors. They gave us the training, which also was that we had to have 1,500 hours of supervision, which I received from the gentleman I purchased the business from.

Your second question regarding children under the age of 18: I do the actual dispensing of the hearing aids for these children as long as they have been recommended by an audiologist and a family physician has given medical clearance for this work.

Mrs Cunningham: My question was in regard to the training too, because spokesmen for your group have been into my office to discuss it with me and from what I can understand, if the training does not change—I am now talking about requirements—and if it is not presented across the province so that there is accessibility, I am just wondering about the future of your work, if you would like to speak to that.

Mr Lebert: Luckily, with my age, I have been able to get into the business young enough. The problem we have as an association is that the average age of the authorizers and dispensers is 55 years old. These people cannot be replaced. So the thousands of people who are being taken care of by these elderly people—watch how I say that—will be lost. There is no one who is out there who will be able to replace these offices.

Because of the George Brown College program that we have been trying to get started, the major downfall is that they do not want us to be able to do the authorizing, so that there has been a great difference there. But these people will not be able to, as I say, in the rural areas, replace their offices because there is no one being trained at the present time.

Mr Beer: Has your organization had any discussion with the audiologists? Is there some compromise position? Are there some, in your view, legitimate concerns about how people might be treated? Is there any other place to go here, or do you think that it is simply a case that you should be allowed to dispense hearing aids to anyone who wants one?

Mr Lebert: I am not on the board of directors for the association, so I cannot answer if they have been meeting. It is my understanding they have. Their viewpoint, to the best of my understanding, is that the audiologists do not want us to do any type of hearing testing or prescribing of a hearing aid, which we do now.

The problem with that is when a person comes into my office with a hearing aid that is five or six years old that needs to be replaced, I have to do the hearing test presently to find out if he needs a stronger hearing aid, or which type of hearing aid needs to be replaced for this person.

The Chair: I have a request from the parliamentary assistant to clarify.

Mr Wessenger: I would just like to indicate that there is nothing in the legislation that will prevent the dispensing of hearing aids.

Mr Lebert: We will not be able to dispense the hearing aid if we do not have the opportunity to do the hearing test to find out what type of hearing aid is needed by that person.

Mr Wessenger: Perhaps I should also clarify there is also nothing in the act that will prevent doing the hearing tests.

Mr Lebert: With the prescription of a hearing aid?

Mr Wessenger: What would be prohibited would be the actual prescription. Of course the definition of prescription has not yet been determined, but that could be either on the order of, for instance, a physician, which could merely be a referral to you to say, "This person needs a hearing aid," and you could go ahead and still do it on the simple order of a physician that indicated the need by the patient.

Mr Lebert: How would a family doctor, or an ear, nose and throat doctor be able to give a prescription that says, "You need a hearing aid," if he does not have an audiogram or any case that says that the person has a hearing loss?

Mr Wessenger: My understanding is that there is going to be flexibility in the administration of this in that it will be up to the physician to make that determination of how specific he is going to be with respect to the question of prescription. I understand it can simply be an order that this person is suitable for obtaining a hearing aid, and it would be up to the medical practitioner to determine whether the situation was such that he felt that the testing was required by an audiologist. I would assume in certain instances, particularly in replacement of hearing aids and so forth, particularly for the elderly, it would be deemed not perhaps necessary to have those tests. I am just surmising here, but I would assume also in the case of young people, obviously those tests would be required.

Mr Lebert: With older people also, we have people who come into our office daily who say they have a hearing loss, "I need a hearing aid." We do a complete case history audiogram on the person, and they have no hearing loss at all. We have to just train the person for better listening techniques, rather than a hearing aid. That is where I see the problem without having an audiogram before the prescription of a hearing aid.

Mr J. Wilson: Madam Chairman, may I just interject a couple of points?

The Chair: We are out of time on this presentation. What you can do is make note of your question, and at the appropriate time place it on the record with the parliamentary assistant.

Thank you for your presentation this morning. We appreciate your appearing before us.

As members know, there will be additional opportunity to discuss these matters. If you have questions that you would like responded to from the ministry, there is an opportunity to do that, or you can place it in written fashion as well.

1040

LOUISE CARROLL

The Chair: Louise Carroll, you have 10 minutes for your presentation.

Ms Carroll: Hello. My name is Louise Carroll. I am a consumer of health care in Ontario. What I want to say first is that I strongly support the overall intent of Bill 43 and its companion legislation, Bill 56. Midwives have a crucial role to play in the evolution of our health care system in Ontario, and I am encouraged to see that midwifery is

finally being given the autonomy and recognition it deserves as a profession.

The implementation of this legislation is personally very important to me. As you can see, I am several months pregnant. London has quality obstetrical services, and there are some wonderful doctors and nurses. Several of my friends during childbirth made a connection with hospital staff on duty. However, the experience of one close friend in particular prompted me to seek alternative care for the birth of my daughter. When my friend recalled her birth story, she said she had felt very alone, uninformed of her progress and felt that she had no active part in decision-making. She was automatically placed into a position where she felt unsupported and powerless to ask for what she wanted.

I chose to increase my chances of a healthy, supported, non-medicated birth by working with a midwife in a hospital. With the midwife, I felt supported in my decisions regarding the birth and felt more comfortable knowing how long I could labour at home before going to the hospital. Even then, because of the lack of legislation regarding midwifery, there were still uncomfortable moments with hospital staff. After the midwife had been involved with so much of the labour, up until reaching the hospital and at the hospital, I really would have been happier if she had been allowed to catch and if that legislation had been in place allowing her to do that.

It is important that women in Ontario have more personal choice available to them in childbirth. Healthier babies and family relationships may result when a woman can give birth with only the people she chooses and knows taking care of her. More specifically, with regard to Bills 43 and 56, I would support any necessary changes which would allow midwives to be primary care givers. These changes would include, but not be limited to, prenatal blood screening, heel pricks, insertion of an intravenous catheter for purposes of rehydration and access to a limited list of drugs for purposes of dispensing.

I would support the timely establishment of autonomous, freestanding birth centres as an obvious way to implement and support this legislation. Midwives need a neutral ground where they can practise, and women and their families need a place where they can have more personal care and choice. An autonomous birth centre would bring about a healthy comparison to the conventional health care system and initiate change within the system more quickly. I would support informed choice, where all health care professionals have a mandate to inform women about their choices, risks and options in child care. I would support holistic midwifery training, where midwives are educated to be familiar with and able to direct clients, when appropriate, to reflexologists, chiropractors, nutritionists, homeopaths, doctors, obstetricians and other health care professionals.

I would support the legislation of homeopathy as a useful profession and model of care. Homeopathy is established and respected in many other countries. As more of the general public becomes aware of the practice and use of homeopathy, it would seem prudent to establish access in a responsible way.

I would support continuity of care within the health system. If a woman has chosen to work with a midwife, in the event that she is transported to hospital, I would recommend that the midwife remain the primary care giver until such time as it is determined that the primary care giver should be an obstetrician. The midwife must remain as a primary support person and, if there are no further complications, resume post-natal care. Finally, I fully support the intent of Bills 43 and 56, with the changes and concerns I have mentioned.

I have a question for the general committee of course: If the midwifery bill has its final reading this fall, can I expect a midwife to catch me in a hospital in Ontario by January? That is my deadline.

The Chair: Thank you very much for your presentation. I have a question from Mr Hope but, Mr Wessinger, would you like to answer the question first?

Mr Hope: I was going to pose that question.

The Chair: Is that your question?

Mr Hope: Yes.

The question and concern I have, in listening to all the presentations on midwifery and looking at her question, is by January and before January could she have the midwife present? It is subject to the hospital's discretionary power, I guess, whether it wants to let a midwife in. Could you just elaborate a little more so that it is clear to me and also to the young lady making the presentation?

Mr Wessinger: I think I will refer that to ministry staff.

Mr Burrows: At the present time midwifery is not a recognized, self-governing profession, so any accommodation the system has for midwives is exactly that. The midwifery task force concluded, and it is on the public record, that presently midwives find themselves operating outside the system and technically operating in an illegal atmosphere. The current thrust of the interim regulatory body being approved by government and this legislation is to rectify that situation. In fact, we recently had a coroner's inquest in Toronto that made very strong recommendations about the need to regulate midwives for the protection of the public. That being the case, the situation that would prevail in January, if this legislation is not passed, would be the same at present: whatever accommodation could be made between those operating outside the system and those who legally operate within the system.

Ms Carroll: However, if the legislation is passed, would that have an effect on something being able to be worked out in January other than what is currently going on, which is an arrangement usually between your own doctor and a midwife?

Mr Burrows: Passage is one thing; proclamation is another. We will not be able to proclaim this legislation immediately upon passage for the simple reason that we have to write regulations under 22 acts and they will need to be vetted in a transparent way. Second, the system has to make whatever changes are necessary to accommodate this, and there are a number of important policy decisions that have yet to be taken, such as practice sites, methods of remuneration, etc.

1050

Ms Carroll: How do you feel about the practice site of a freestanding birth centre?

The Chair: That is a question for the parliamentary assistant, not for ministry staff. We will put that to the parliamentary assistant, if you wish to answer.

Mr Wessinger: I think it is a very interesting concept. It is really just a question of determining what the appropriate location is and so forth.

Ms Carroll: Do you feel it would implement the legislation faster and allow it to be more real, more practical and more usable by consumers?

Mr Wessinger: I am only speaking personally in this case. I think it is a good concept and certainly I would like to see it implemented in some manner.

Mr Beer: Madam Chair, as you know, the Independent Health Facilities Act, which the previous government brought in, was to allow for the development of proposals for a variety of services, and undoubtedly that will be one of the proposals that would be coming forward.

The question I want to ask you really does deal with what you might face in January or even after the legislation, the regulations and so on are there. What has been your experience, in working with the health care professionals who are there, doctors and nurses, around your having a midwife? Clearly we know you can have legislation and regulations, but we are working on an attitude change. What is your sense of where those other professions are in acceptance of midwifery?

Ms Carroll: My daughter is now a year and a half old. Even in the last year and a half things have started to change, and I can only speak for the London area. Things have changed a little bit in some areas. I cannot say there have been major changes. Even if this legislation comes through, it is going to depend on how nurses and doctors react to this. Some people are reacting and looking forward to this as being an evolution, something that really has to come to truly give meaningful, personal care, and other people are feeling threatened by it. That is my impression.

The Chair: Perhaps I could be helpful for members of the committee, as I have some information regarding your question about January. The interim council has also determined that all midwives who are presently practising in Ontario would require educational upgrading before they would be able to practise as primary care givers within the health system in Ontario. It is contemplated that it would take approximately two years before that could happen, and that would allow the system to make the adjustments necessary and allow for the implementation of this legislation.

The answer to you is no, that would not be possible this coming January even if this legislation were passed and proclaimed, because of the educational requirements as recommended by the interim council. However, over the course of the next little while, provided this legislation is passed and the education program put in place, you will see the gradual implementation through hospitals as well as ultimately independent birthing centres, I believe. That

is contemplated by government policy, and I have heard no change in that policy.

Ms Carroll: If you choose to have a midwife attend your birth, I guess it is still going to come down to your having to connect either with a family physician or an obstetrician who is willing to support that choice and allow you to do that. That is probably going to continue for two or three years.

The Chair: That is correct.

Ms Carroll: It is disheartening for me in one sense, because even when I had a midwife with a family doctor who was open to having that, but still wanting to maintain control of the catch, the last 20 minutes before he arrived—that is one of the concessions you make when you do that. It is funny; it is still even being in that hospital setting and even just trying to work. If I am not able to have a midwife with me this time, at least I know I am going to have a patient advocate with me, someone who can handle the politics, and I can just focus on the labour and being with my family and will not have to deal with some of the people who are wanting me to be—in my own personal experience, for example, I was on a birthing stool, I was ready to push and things were going well and the nurses were so concerned that I should be up on the bed and ready before the doctor got there. But when my doctor arrived he just said: "Great, fine, that's good. Things are going well. Let's go with it." It is the perception of what people should be doing, and really the focus should be on working with that person and supporting her in labour and helping her to have a really joyous birth and bringing that back. I think that is what is really important.

The Chair: Thank you very much for your presentation before the committee. If there is any additional information that you think would be helpful to the committee, please feel free to submit it in writing at any time.

Ms Carroll: Thank you very much.

GUS SCHEID

The Chair: Welcome, Dr Gus Scheid. You have 10 minutes for your presentation.

Dr Scheid: My name is Dr Gus Scheid and I am chief psychologist at St Thomas Psychiatric Hospital in St Thomas. First, I thank the committee for the opportunity to present to it.

My general reaction to the proposed legislation is an extremely positive one. It renders the regulated professions accountable to the public, protects the Ontario citizen from unqualified practitioners, provides a spectrum of informed choices for those seeking health care and provides a quality assurance mechanism for professional clinicians in various disciplines. It has been long in coming and should be most welcome by the health professionals and consumers in Ontario.

This having been said, I have four points to make with some problems I have specific to Bill 63, the regulation of the profession of psychology. First, provincial regulation by law is not new to the profession of psychology; 31 years ago the Psychologists Registration Act of 1960 restricted the use of the title "psychologist" to those registered under

the act and set up a governing body, the Ontario Board of Examiners in Psychology, to determine registration requirements and protect the public by enforcing standards and quality assurance for those in the profession.

The same act prohibits anyone, except those who are registered, from holding himself or herself "out to the public by any title, designation or description incorporating the words 'psychological,' 'psychologist' or 'psychology.'" The act simply protects these titles without in any way interfering with other disciplines in their offering of therapy or counselling.

The act currently before Parliament, on the other hand, significantly erodes the protection which the 1960 legislation provided to the Ontario public by restricting only the title "psychologist" and not restricting the use of the related words "psychological" and "psychology." Thus, anyone at all with any or no qualifications can represent himself or herself as a psychological consultant or as having a practice in psychology or in any of the countless ways in which words signifying something similar can be combined.

Without the least fear of error, I maintain that the general public will never be sophisticated enough to distinguish between registered, qualified, controlled and accountable members of the college and others who use such appellations of themselves. I believe the government has an obligation to protect the public by framing the language of the RHPA, and specifically Bill 63, to protect the words "psychology" and "psychological" and their variations or abbreviations. This protection can be provided without penalizing any other professional group.

Second, in subsection 15(1) of Bill 63, the title of "psychologist" is restricted to members of the new college for those providing "health care." By regulating only those psychologists who provide health care, the present legislation removes a very large number of psychologists who were previously regulated under the 1960 legislation and absolves them from any regulatory control at all. Once again, I believe this is an enormous disservice to the public. When I seek to employ a lawyer, I expect him or her to be fully registered with and regulated by the bar, whether my need for a lawyer is in regard to real estate, a divorce action, a civil suit or a criminal defence on a murder charge. Why should the public expect any less protection in the case of a psychologist? Is it any less important that a psychologist in an educational, industrial or organizational setting be qualified, registered and regulated than a psychologist in a health care setting?

"Health care" can, and likely would be, interpreted very strictly and conservatively. I would strongly suggest that the limitation created by the "health care" words in subsection 15(1) of Bill 63 be removed by simply removing the words from that part of the act, thereby regulating all psychologists and increasing protection of the consumer.

Third, psychologists are one of the five groups accorded the licensed act of diagnosis. I have been given to understand that there is a lobby against psychologists being licensed to diagnose. Given its importance, I cannot conceive of diagnosis itself ceasing to be a licensed act. Given that, it seems that psychologists should remain one of those groups licensed to diagnose for the following reasons.

1100

1. Psychologists receive formal training in diagnostic assessment and indeed possess a psychometric technology available to no other profession.

2. Many psychologists have practices entirely devoted to diagnosis.

3. Many multidisciplinary teams, such as those in our hospital, frequently look to psychology for their diagnosis.

4. Psychologists being licensed to diagnose in no way threatens the work of unregulated professionals.

Finally, there is the issue of entry level for registration with the College of Psychologists of Ontario created by the RHPA. I realize there is a lobby to weaken the registration requirements from those which the Ontario Board of Examiners in Psychology currently require.

The lobby to diminish registration requirements began in the early 1980s when Mr Schwartz and his committee were giving birth to the current proposed legislation. After careful examination, the committee elected to leave the requirements as they are today. I applaud this decision and think any other would further erode public protection and quality control. Consider the following.

All across North America most jurisdictions require the doctorate for registration in psychology. Those few that do not are moving in that direction. What would prompt Ontario to regress to lesser standards?

Would the Legislature entertain lowering entry level requirements for dentists or for surgeons? If not, what is the difference?

In the early 1980s, an analysis was conducted on the examination requirements for registration as a psychologist. It was concluded that it was inconceivable to allow people to sit for these examinations pre-doctorally.

Many of those who are currently lobbying for a reduced requirement for registration as a psychologist have their backgrounds in areas totally other than psychology.

Keeping the current registration requirements does not interfere with any group's practice of its profession. They simply cannot be registered as psychologists.

Finally, I believe the entry level issue should not even be debated in this context. It is outside the scope of this legislation, as I understand the act. The college established by the act, as with other regulated profession, should determine the issue for the profession.

I thank you for your time.

Mr J. Wilson: Thank you for your presentation. You made your points very clear. I am going to ask you anyway, under the area of title protection, your first point and fourth point, we have had evidence before this committee that a number of the non-doctoral practitioners, many unregulated psychologists, for a lack of any other terminology in this committee, who seldom ever see a PhD, are practising, for instance, in northern Ontario. They are very much worried that their practice would be threatened. I am worried in that context.

Although you make it clear that you do not feel this is part of the bill, I think it is in the context that if we continue to extend title protection to the terms "psychological" and "psychologist" and "psychology," the three terms, and if the agreement that has been worked out, the task force

that has been established to work together over the next 18 months between the non-doctorals and the members of the college, were to fall apart in some way and an agreement is not reached, I am worried that by giving the full title protection we would somehow be impeding those non-doctoral practitioners. Do you want to comment on that?

Dr Scheid: I do not think the fact that there are some communities in outlying areas which have a difficult time attracting doctoral-level people is any reason to modify legislation that applies across the province when we are trying to achieve certain standards. I think that is an exception. I think it is great they are there. When their absence would mean no resources at all, I think it is great they are there. Also, I do not think it impedes anybody's practice. Any member of this committee could rent a room in this hotel and hang a shingle out saying "Psychotherapist" or "Counsellor" or "Shrink" or anything you want to call yourself, except you cannot call yourself a psychologist. I think that is fair enough. I think you can practise your profession and do the kind of work you are trained to do without using that title if you are not entitled to or qualified to have that title.

Ms Haeck: Dr Scheid, I am sorry that I was not here for all of your presentation, but I did notice something right when I came in. As a politician, I have come to know very quickly that perception is really all of reality. I make a large assumption, and that is that your views are your own and not those of the Ministry of Health, whose letterhead you have used.

Dr Scheid: That probably is a misjudgment on my part. What happened was our assistant administrator forwarded a memo from Janice Buchanan saying that invitation was issued. I gave this to my secretary to type, I am afraid, without checking. I apologize for that.

Ms Haeck: I understand how these things do work, but I do want to give you the opportunity of clarifying that.

Dr Scheid: This is my personal position as a member of the psychological profession.

Ms Haeck: Okay, very good. Thank you very much.

The Chair: Thank you for your presentation. We appreciate your appearing before the committee today.

DAVID BREZNIK

The Chair: Mr David Breznik, welcome to the standing committee on social development. You have 10 minutes for your presentation. We ask if you would leave a few minutes at the end for questions from committee members.

Mr Breznik: Ten minutes is not long for all I want to say, but I am going to do my best with it. I wish to respond to Bill 56, An Act respecting the regulation of the Profession of Midwifery. I come before you on two points: (1) having a daughter who wants to get into this and (2) my wife and I would like to have a midwife for our next birth.

Throughout our lives we are confronted with situations and decisions relating to authority. Each one of us here is under an authority. Authority provides for us an umbrella of protections, and our character is shown through our response to these authorities. This presentation is not a condemnation of the authority of the proposed college, but

it is an appeal to the authorities responsible for the design of Bill 56.

Realizing there are instances where help may be required, we believe birth should be viewed as a natural function and not a medical procedure. Birth will occur whether or not medical training and facilities are available.

We are concerned that this bill will deprive women of choice in selecting a midwife, discriminate against young married women who may choose to enter the workforce as a midwife, hinder women from making their own decisions on what is happening within and with their bodies and attract the wrong candidates for the field of midwifery.

The proposed act states in section 15 that no one, unless a member of the proposed college, practise as a midwife in Ontario. I see no provision for acceptance of licences or accreditation from other licensing bodies from within this country or from without.

I recently read an account of a woman whose mother noticed that she was not responding as a normal child when she was born. Her mother took her to many doctors and specialists. Many tests were done and they all said basically the same thing, that she would have to be institutionalized for the rest of her life. Until the age of 11 she lived five days a week in institutions where she was under treatment in various programs, coming home on weekends.

When she was 11 years of age her father received a transfer to the company's European branch. They took their daughter with them. They brought her to a specialist in Europe who examined her and gave her a diagnosis and prescribed treatment. Within 10 days she was responding as a normal child. They later returned to North America and she went on to graduate from college at the top of the dean's honour list. Just shortly after graduation she went by the institution where she had been and visited some of the children she had been in with. They were still there.

The medical profession in this case was limited by its training. Please, I appeal to you, please try and avoid this pitfall. Do not have a narrow view. Allow for acceptance of other accreditations. Make provisions for the training of midwives from other than the proposed college. Please do not deny choice to women who wish the services of a midwife who is accredited elsewhere, nor to those women who wish to receive their training, for whatever reason, from a course other than that of the proposed college.

In preparing for this presentation, I held conversations with many practising midwives throughout this province. Some have been on committees in preparation for this legislation. I have been informed this course will be from three to four years, although no one could tell me for sure. I submit that anything over one year will place hardships on those women wishing to become midwives and will especially discriminate against young married women with young families wishing to enter the workforce. A young married woman with small children, living some distance from the proposed college, as is very likely in this province, would have to leave her young family for a semester at a time. This would put undue hardship on both the women and their families, and many would not be able to make this decision.

At one time our doctors, lawyers and many other professionals were trained through apprenticeship. I am personally in favour of apprenticeship, as it tends to reduce the amount of peripherals and also brings a better understanding.

Years back I was employed by Ontario Hydro in the nuclear power division. When I was hired I was sent to their training centre. They taught a lot. However, it meant little as I had never been in a nuclear plant and I could not relate to the systems and devices they were discussing. However, after a few months working in the plant I wished I could have had a repeat of that training as now I saw the systems and devices and I could relate and ask questions.

Apprenticeship: There are few portions of this province that do not have a midwife whom someone could apprentice under. They could train under a midwife and return to a training facility after so many births for a two- or three-week course to ask questions, to learn different procedures and methods and to receive advice.

An apprenticeship based on perhaps 75 assists and maybe 25 births, which will include several months of classroom training that will be broken out over a period of time that would reduce the hardship and stress, would go a long way to eliminate discrimination against young mothers with children and those living in remote areas of the province. It would also reduce costs by eliminating courses not essential to the practice of midwifery.

1110

When a family expecting a child decides to have a home birth, they make this choice for one or all of many reasons, one of which is the ability of the family to make their own decisions. When our children were born, I was with my wife for most of the time in the hospital. We cannot recall anyone, doctors, nurses or even orderlies, asking us if we would like this procedure, that procedure, this position or that test, or even discussing anything with us. We were not consulted or asked; things were just done. We had no say and we were not expected to have a say. After our last child was born, my wife said never again would she allow that to happen to her. We then decided we would have the next child at home and my wife and I would make the decisions.

We have a concern that if this proposed college is going to be the only place to allow membership to practise as a midwife, and it has a long-drawn-out course, it will eventually support birthing hospitals and birthing homes. It will affect the private home birth by bringing the atmosphere of a hospital-like setting with all of its businesslike starkness to the home, and the decisions of the women as to what is happening to them will take a back seat to procedure and efficiency.

Midwifery is already recognized and legitimated by those who are using the service. When, through this legislation, it becomes officially recognized and financially backed by the guaranteed payments of OHIP, we have a concern over reasons why applications will be made to this course. We have a concern that whereas now those who are engaged in midwifery are doing so because they enjoy doing this, because they have found they have natural abilities and people skills, once this is a degree program it will attract those who want a career and not provide a service.

We have a strong concern that those with the natural skills but not the academic ability will not be able to gain entrance. Some who are accepted may excel in midwifery courses but fail in peripheral courses which will deny them becoming members of this proposed college.

I see it as like a car mechanic, somebody who is really good under the hood of a car and makes that car purr, who is told he has to go for three or four years' training at a college. When he gets there, he passes all the mechanics courses but fails the rest and is denied the licence to be a mechanic. We will have licensed people with degrees and certificates, but will we have people with understanding, with wisdom, with knowledge? Will we have people with character who are diligent and dependable, who have the character of being patient and responsible? Will we have people who are sensitive and gentle, who are compassionate? Or will we have people with a good business and a career?

This act, as we have seen it, does not address what will happen to those who are already practising midwives or those who are currently taking their training out of province. It does not address the length of time involved or the courses to be taught. It does not address any provision for religious conviction. In my discussions with midwives throughout the province, I had several mention that they would flatly refuse to take some of the courses that have been proposed, such as psychology or relaxation methods based on eastern religious techniques.

To summarize, I appeal to you to recommend that we do not limit ourselves and place obstacles in front of women by allowing for only one body that can train midwives. I appeal to you to emphasize apprenticeship and thereby remove a discrimination against young married women. I also appeal that you recommend that members of the board of this proposed college not be comprised wholly of doctors and nurses but also be made up of members of the interested public and that there is an equal representation of midwives from around the province.

While I was preparing this and was talking to various people, one woman did send me a letter which so came close to what my wife and I believe I included it with this. Thank you.

The Chair: All of the members of the committee have received your written presentation, including the letter you referred to.

Ms Haec: Thank you very much, Mr Breznik. It is always good to hear from the consumers of these services. You make some very good points. At this time, just for clarification, I am going to direct my question to the PA and ministry staff. It is my understanding that in the concept of the whole legislative package the colleges would be doing the regulation of who in fact would be forming their membership. The quality assurance portion of Mr Breznik's recommendations would also fall within partial regulation. They would be half public and half members of the college. Can you, just for clarification, comment on those points?

Mr Wessenger: That is correct. It will be the governing body that will be determining these matters. Of course we have not yet set down the whole question of what

standards will be applicable, both to existing midwives and to new entrants into the profession, but I think one thing we have to remember is that there is quite an extension of authority being granted to midwives. They are moving from working in a supervised setting to, in effect, having an independent role. Obviously we have to protect the public in this regard.

Mr Beer: My question relates to your concerns about how midwives are going to be trained and how they are going to be licensed. If you look at the development of this in a political sense, I think there has been a broad spectrum of agreement right from 1987 when Murray Elston, who I think was then the minister, announced there would be regulation of midwifery through the Independent Health Facilities Act which would allow for independent birthing centres, and the present government that has continued to support the development of midwifery. Do you not believe, within that, there still needs to be, for the protection of the public, protection of standards? As has been stated the majority of members of that college would be midwives along with people from the public. Could we place our faith and our trust in them to establish the kinds of standards that would both protect the public and meet many of the concerns you have?

Mr Breznik: I would hope a lot of the board would be made up of midwives but I have a concern that a lot of those midwives may have graduated from nursing school and they would have a different outlook towards it than somebody who just went in to midwifery. The question that comes to me from that is, if my daughter took training in the United States, would she then be accepted here as a midwife?

Mr Beer: But I think one of the things the college would be doing is looking at programs, how they would accredit programs from different countries, how they would deal with those midwives who are already here who could perhaps be accepted because of the training. Those are issues that, in effect, midwives would be determining and dealing with. I would think they are the appropriate people we would be turning to for that kind of decision.

The Chair: This is the first time that we have had a consumer of a service ask a question regarding who makes the decisions in a self-regulating regime. Just for your information, and for any of those that are interested in this point, in a self-regulating framework it is up to the profession, through the professional colleges as differentiated from the educational college or university, who would establish entry to practise for the profession as well as standards of practice, quality assurance programs, educational requirements. The membership of that college will be determined by the legislation. But the legislators, including the government, will not be making those decisions. This confers self-regulatory and self-governing status on the professions that meet the criteria for that status.

Mr Breznik: So who sets up the board for that?

The Chair: The board is established in accordance with the legislation that is proposed and the professionals themselves elect members to that council. The government appoints individuals who are the public representatives on that council and, just for your information, and I am sure

the midwifery task force would be happy to clarify this for you, there has been an interim council set in place, because this is a new profession and it has been ongoing for quite some time now, to allow for the implementation of a new profession in Ontario. I am sure the ministry staff, parliamentary assistant, and others would be happy to answer any of the technical questions as to how this will work.

Thank you very much for your presentation today. If there is any additional information you feel would be helpful to the committee, you can at any time communicate with us in writing, and if you have any questions, I would encourage you to discuss them with the parliamentary assistant or with Mr Burroughs.

1120

A. DALE VELLETT

The Chair: Next is A. Dale VelleTT.

Dr VelleTT: My name is Dr VelleTT. I am from University Hospital. I am the director of body magnetic resonance imaging at the hospital and this representation is really on behalf of the technologists who run our magnetic resonance imaging unit. By necessity, almost all of the technologists are recruited from either nuclear medicine specialties or radiation technology specialties. We have no formal specialization of radiation technologists per se in magnetic resonance imaging, the problem being that once they are seconded to operate and run a magnetic resonance scanner, they stand a real risk of losing their accreditation with their original specialties such as nuclear medicine or radiation technology. So this presentation is really fairly simple. That is, is there no way of one circumventing this possible loss of accreditation? Is there no mechanism we can put in place that will allow them to retain their accreditation out, at the same time, work in magnetic resonance imaging?

Mr Wessenger: I will refer that to ministry staff.

Mr Burrows: This legislation would permit such things as stratified registers within the colleges. For example, if they wished to categorize a certain group of practitioners who had expertise in a certain area, that is allowable under this legislation. There is nothing preventing it. The standards that would apply both for entry and for continuing competence and quality assurance would again be decided by the governing body, the college. So one would expect this issue would be considered by the relevant college or colleges at the time of developing the regulations for entry to practise and for the quality assurance program.

I would also indicate that the Ministry of Health is aware of this particular issue and we have had discussions with some of the various associations who are represented in this. We would not see this as an insurmountable problem. Hopefully the system will accommodate that, because it is certainly not the intention of the ministry, or I think anyone affected in this, to eliminate or prohibit in any way people from maintaining their competence.

Dr VelleTT: Is there any formal body one should then make a formal representation to, or should one leave this to the mechanism?

Mr Burrows: I would suggest that you continue to stay in contact with my branch and we will make sure that you talk to the appropriate people. I will give you a card.

Dr VelleTT: Good. Thanks very much. That is all I have.

The Chair: Thank you very much for your presentation. If there is any additional information at any time, please feel free to communicate with the committee via the clerk.

JERRY BANKS

The Chair: I call next Jerry Banks.

Mr Banks: Thank you. I am nervous.

The Chair: Do not be nervous.

Mr Banks: I could stand up in front of 2,000 people with a guitar on my shoulder and sing for four hours. To talk to you for five minutes, this could be a problem.

The Chair: It is not a problem. Would everyone please smile so—there you go. All right, Mr Banks, just relax.

Mr Banks: My name is Jerry Banks and I have just driven 120 miles to express my concerns about Bills 43 and 57. I am a retired person, two months, and I am disgruntled with the way you are proposing to spend my health care dollars. If these bills pass as they are presented, the nursing care that I will receive will be almost non-existent, the way I interpret it. This is me; I am not a doctor, I am not a nurse, I am nothing, okay? I have worked at several jobs through my life. I want you to understand that my education is only what we called the senior matriculation. I do not know what you call it now.

Nurses are capable of performing approximately 60% of the activities of a physician, at a considerably lower rate of pay. They should not be restricted in the activities for which they are trained and they do now. The recent well-deserved pay increase should reflect our endorsement of their professional judgements. Nurses need to be given more freedom to counsel, teach and promote the best health care for their patients.

A nurse uses independent assessment of her needs, formulates a blueprint for care, carries out that plan and then evaluates the successfulness of the strategy. The nurse is my advocate when I do not hear or understand the physician; and believe me, I am deaf. His language is not that of the general public and very often needs translation. It is the nurse who is the front-line contact for me, the public, and needs to have the freedom to assess, to start treatment, counsel and educate as necessary without having to wait for the arrival of a physician from his office or you know where, a golf course or boat or up in the operating room delivering babies or whatever he is doing. Thus I feel the controlled act number 1 should definitely be included in the responsibilities of nursing.

The standing committee hearings are being held in major centres where teaching hospitals are found. Not one outlying area was selected for an area presentation. It is in these areas where the nurses need to nurse. Previously a large number of activities were deemed by physicians to be in their realm of practice. These duties were delegated to a nurse with additional training. However, the responsibility for conducting these acts was offered to the College of Nurses, which accepted the responsibility. Therefore,

these delegated medical acts now become added nursing skills, entirely under the umbrella of nursing and the sphere of nursing practice. These skills may be performed by nurses with medicine's blessing. Now the government is opting to reverse this tried and true progression of health care.

Nursing should definitely be encouraged to apply and order forms of energy, as in controlled act number 7. The nurse applies and did apply the cardiac monitor to my chest and has the expertise to read the tracings and act upon the irregularities. It is the nurse who suction a choking patient whether it be an adult or child. Waiting until the situation becomes an emergency is not good enough. Give nurses the freedom to exercise judgement and act responsibly as they are trained.

With regard to controlled act number 8, nurses are always in charge of medicine rooms and carts. I have seen the keys around their necks and so have you. If you have ever been in the hospital, you have all seen it. The nurse at the summer camp my grandchildren attended was the one who dispensed the hay fever decongestants and pain medicines.

Many areas of the province, including my own of Grey-Bruce, are not serviced by university-based hospitals where there is an abundance of interns and clerks of many health professions at the ready for 24-hour coverage. Nurses give care on a 24-hour basis. Many other professions that would be regulated under this act have bankers' hours, from nine to five Monday to Friday. Who will give the care on the weekends and the afternoon shifts and night shifts?

Nurses view the patient as a whole human being, physically, mentally and spiritually. Their care is not fragmented. Rather they are the ones who co-ordinate care and should not be simply assigned to follow orders. I feel controlled acts 1, 7, 8 and 11 should be deemed in the scope of the nursing practice and the rider, "on the order of a qualified person" should be removed from acts 2, 5 and 6. In addition, other areas of concern that need to be performed by nursing with additional training or in the areas not really serviced by a physician should be permitted at the discretion of the college of nurses. After all, if the college of nurses is being set up under this legislation, the college should be the evaluator of the controlled acts that its members are trained and competent to perform.

I trust these points of concern may be addressed and I thank you for allowing me to speak. I want to add a footnote, ladies and gentlemen. These are my concerns. Whether I am right or whether I am wrong, these are mine. If I interpreted some part of the act wrong it is because I did not have much guidance. I have talked to a few nurses, a few physicians, a couple of surgeons and I thought I had better do something. I have worked 18 hours a day all my life and now I am not doing anything, so I thought I would do something. Thank you very much.

The Chair: Mr Banks, thank you very much for an excellent and thoughtful presentation. The committee has been very keen to hear from consumers of health services and I know your presentation has been well received because there are a couple people who would like to ask you some questions. The other thing I think I can say on behalf of all the committee members is you did not look a bit nervous.

Mr J. Wilson: Mr Banks, you made a very good presentation. A number of the points you have made have been expressed by nurses themselves and certainly the government has made it clear and the opposition parties made it clear that it really is not the intent of the legislation to narrow the scope of practice of nurses and we are all going to work together in a non-partisan fashion to try and bring in amendments that will loosen it up.

Mr Banks: I am sure you will. I was an orderly for a while in my working years. I did not want to be, but I was. I have to say that something like this was a long time coming. Nobody has looked at this for I am guessing 20 years or more, probably before my grandchildren were even born. Somebody told me this has been on the table for about eight years. I know my government now, you people, will not let it go much longer. I have full confidence that you are going to look after this and get the show on the road.

Mr J. Wilson: I should ask what your definition of "my government" is.

Mr Banks: My government is everybody who sits in Queen's Park who represents Jerry Banks the taxpayer.

The Chair: Mr Banks, just a minute. Before you leave, I have a comment from the parliamentary assistant.

Mr Wessenger: Mr Banks, I would like to thank you for your presentation. In fact we think this legislation will give the nurses much more power. First of all, they can act in emergency situations. Second, there is provision for delegation to nurses. Third, when you bring out this question on the order of a qualified person, the College of Nurses of Ontario itself can set up a nurse as a qualified person. I know you did not understand that, but it really is a very much expanded role. This is quite unusual in the sense that the college of nurses itself can expand the role nurses can play, and the thought is that as nurses get special qualifications they can assume more and more responsibility. We have thought of that and we are working on it.

1130

Mr Banks: Oh, great. That relieves me some.

Mr Wessenger: I really appreciate the spirit of what you presented today. Thank you.

The Chair: I have one more question for you from Ms Haack. There is just one minute.

Ms Haack: I appreciate all your comments and I will not repeat exactly what Mr Wessenger put forward. Having worked in a hospital you are probably aware that the hospital practice usually contains standing orders and that nurses and a lot of the hospital staff function under those. In emergency situations they deal with that situation as it arises. Are you aware of those situations?

Mr Banks: No. You mean I do not have to lie there and choke till the doctor comes in from the golf course?

Ms Haack: Not at all. Part of the whole issue of standing orders is that if these situations do arise, if an emergency room doctor or your own doctor is not there, they are empowered to carry out the proper practice. How is that?

Mr Banks: That sounds better.

The Chair: Thank you for your presentation. I would like to ask a question. Was the experience as bad as you expected?

Mr Banks: No, it is not that bad, but I would sooner sing it.

TOM HEBERT

The Chair: Tom Hebert, come forward. Welcome to the committee.

Mr Hebert: Thank you. I want to address the impact of this legislation on the practice of orderlies within the province of Ontario. I work in a hospital in Windsor, the Metropolitan General Hospital. I have been an orderly there for 22 years. As far as I know, orderlies at least within the city of Windsor and throughout southwestern Ontario have been in existence and performing the same acts I do now for at least 56 years, and possibly prior to that. I do not believe that orderlies are limited to southwestern Ontario though. I believe there are numbers of them throughout the province. My best estimate, although it is only an estimate, is that there are approximately 1,000 in Ontario.

My concern is with the prohibited acts. As they affect orderlies, they would involve urinary catheterization, enemas and actions surrounding those two basic functions. With urinary catheterizations, you have as ancillary to that irrigations of the bladder, both continuous and manual irrigations. With enemas, from time to time you have the need for disimpaction as well. Orderlies generally also give suppositories and perform tasks such as that. As I say, those are the two primary areas I am concerned about.

What has developed over a number of years is a delegation by registered nurses and doctors of these functions to orderlies because of the female-dominated nature of the nursing profession. I am sure everyone is aware of the discomfort many female patients will express or have expressed in the past about the lack of ability to go to a female doctor for some of the procedures because they are of an intimate nature. These particular procedures are of an intimate nature for males, and it has been felt for all this time that most men are more comfortable if a male performs them. That was the origin, I believe, of the delegation.

The skills are acquired through training by registered nurses or doctors. It is basically on-the-job training in a clinical skill and that is monitored. As you are working, the results of the care and treatment are being continually monitored because it is within the health care setting. As I say, the emphasis is on the clinical skills. Once a procedure is explained, developed and practised, the expertise that is necessary for the protection of the public is there. Of course you do not want an independent practice outside of the health care setting because clearly, from everybody's point of view, that would be inappropriate; but within a health care setting, by delegation or by exemption and that sort of thing, orderlies can continue to function and perform their ordinary tasks and have other tasks delegated to them from time to time depending on training and skill.

At the end of my written submission I have appended the policy of the College of Physicians and Surgeons of Ontario on delegated medical acts, which delegate certain

tasks to nurses and other health care professionals. That, I think, is a very useful model for considering regulations for other health care professionals because it specifies certain categories or acts which should be delegated to a registered nurse. While they do not do it in this particular enactment, the College of Physicians and Surgeons could specify respiratory therapists or medical lab technologists or any other regulated health profession to have governance or delegation of certain actions, controlled acts.

On the other hand, they also take certain acts and delegate them to a designated person who is trained in the procedure and certified in the procedure. Once that training and certification exists, that person is then competent to perform those procedures. I think that is a balanced approach for registered nurses and it is also a balanced approach for orderlies, as and if the nursing profession or the medical profession want to expand their scope of practice.

Basically that is what I want to bring to the attention of the committee because, as I say, the particular prohibitions would prohibit urinary catheterization and the giving of enemas and disimpactions, things of this nature, on patients because they are beyond the urinary meatus or beyond the anal verge. Certainly, on behalf of myself and other orderlies, I would like an exemption from that or delegation, or both, to deal with that situation.

As I say, orderlies have been performing these tasks within Ontario for at least 50 years and probably quite a few years before that. They have grown with the profession and are integrated into the health care system, particularly in public hospitals but also in some of the other institutions, the nursing homes and things of this nature. They also are often involved in psychiatric patient care as psychiatric attendants, with many of the same duties. Urinary catheterization also comes up in those institutions; so do enemas. Those are tasks that are ordinarily performed by orderlies, among other health care professionals.

In the United States, just recently the American Medical Association has instituted a program to parallel both the registered nurse and licensed practical nurse programs to bring more people into the health care system. It is called the registered care technologists proposal, and they have set up pilot programs to train people in three levels of delivering care to patients. Their idea is to supplement the auxiliary nature of people who are able to help nurses and LPNs in their practice, and to deal to some degree with the problems that come up with the shortage of nurses and things of this nature in the US.

That proposal is still in the pilot program stage, but it is some indication of the way in which the US is perhaps going to be dealing with these issues. They will be proposing licensure. I would suggest, in the longer term, that licensure might be a route for us to go as well with the College of Nurses, either licensure of the group itself or licensure of the particular delegated acts and procedures.

1140

The Chair: Thank you for your presentation. If there is anything additional that you think would be helpful for the committee, we have all received your presentation, and you certainly can continue to communicate with us in writing.

The parliamentary assistant has asked to clarify some of the questions.

Mr Wessenger: I would like to add that we do not see this legislation as having an impact on orderlies, for the simple reason that section 27 of the act still permits delegation by a health profession and we can see that continuing. We still see standing orders continuing which would allow you to do certain acts.

The other things with respect to outside of the institutional setting, there is an intention to exempt attendant care by regulation with respect to the matter of care given in nursing homes, for instance, and so forth. This type of activity would be permitted in the nursing home setting under the regulations.

Mr Hebert: Thank you very much, sir. I realize that exemption was there. I believe Mrs Caplan first mentioned it and then it was confirmed by Mrs Gigantes in a statement to the Legislature when the bills were introduced. My concern is that you be aware of this problem and that the delegation by regulation address itself to the idea of orderlies and others performing these tasks.

The Chair: Thank you very much for appearing before the committee today. For your information and everyone else's, Hansard is here. Your presentation is on the record and your written presentation is also part of the public record.

BARBARA CONLON

The Chair: Barbara Conlon, come forward. Welcome to the committee.

Ms Conlon: Good morning, Madam Chairperson and members of the standing committee, and welcome to London. I am pleased to be able to present my concerns with Bill 57, the Nursing Act, as part of Bill 43, the Regulated Health Professions Act. I appreciate the commitment you have made to hearing my feelings on how this proposed bill will certainly affect the present level of health care I am able to offer.

My name is Barbara Conlon. I am a registered nurse working in a large health centre for southwestern Ontario currently designated as an obstetrical tertiary care centre. The past 16 years I have spent in the field of perinatology, the care of mother and foetus, aimed at an outcome of a healthy mother and child. By relating some personal experiences I will demonstrate how this bill will affect the delivery of safe and optimal care in my field of practice.

Working in a hospital places me in the unique position of being an employee subject to the directions of my employer, as well as being regulated by an outside governing body. As an employee, I am obligated to my employer even if I feel it may compromise patient care. For example, I am told, "Next Sunday you're one nurse short and she won't be replaced." The delivery room is very unpredictable and situations demanding nursing care are always changing. I realize this can lead to a potentially dangerous situation for my patients. I know I will not be able to give the optimal care deserved by my patients. The employer has failed to recognize my needs to work under conditions conducive to giving optimal care.

As an employee, I am under the control of nursing managers and supervisors. A supervisor will decide numerous things in a day, all of which will affect the care given to the patient, for example: "The sick call won't be replaced. You'll have to work short. I know you're busy, but you'll have to do the best you can. I know you can do it," or: "Barb, you have to go to ICU. They're busy. Yes, I realize you haven't worked in ICU, but a nurse is a nurse and they need a body. You have to go. If you refuse, I'll speak to your manager."

Ladies and gentlemen, the above examples happen every day. I am being asked to be part of a dangerous and unsafe situation which could leave the patient in a compromising situation. Because I am a hands-on care giver, because I am the person with the most patient contact, I will be the person who has to answer for her actions if any questions should arise. The supervisor/manager who decided not to replace staff, to send me to ICU, may answer to another manager but not to her governing body as she or he is not designated as the hands-on care giver. Obviously patients are ultimately affected by their decisions and, for this reason, I feel administrators, supervisors and teachers must be held accountable.

By not including these nurses in our scope of practice, by not recognizing the role of the employer in the delivery of safe and optimal care, this bill has failed to address a serious ongoing situation. I fear that examples such as I have cited are only going to continue to escalate. Protection of the public through safe patient care is lost. The budget, as important as it is to all taxpayers, is often the only concern, unfortunately at the expense of patient safety.

With the introduction of this bill you are opening the door to fragmentation of the health care system. Without licensing of my scope of practice you have allowed other less qualified health care personnel to perform my functions, most likely at a lesser cost. Licensing denotes control over. Without this, employers will feel free to substitute a somewhat less consistent caring approach for a more skilled and experienced nursing care, as well as a higher level of safety.

For example, respiratory technologists are now suctioning neonates' endotracheal tubes and attending deliveries of the potentially ill foetuses. In an outpatient department for high-risk pregnancies secretaries with no medical background are weighing patients and checking urine for protein and glucose.

Both these sets of workers feel this is great; it gives them more justification for their position. But tell me, is that respiratory technologist giving the same compassionate care as the nurse who is at that bedside of that sick infant 24 hours a day? Can they assess the baby's reaction when they have another 10 infants to suction? Will they be readily available if emergency suctioning is needed? Having worked in the neonatal intensive care unit for eight years, my answer would be no.

In the case of the secretary, would she be able to recognize the significance of too much or too little weight gain? Would she be able to counsel the patient as to Canada's Food Guide and pregnancy? Would she be able to recognize the symptoms of pregnancy-induced hypertension?

Having worked in the high-risk obstetrical department for eight years, my answer is no.

Licensing of my scope of practice would protect the patient's right to safe and adequate care and help to maintain my level of job satisfaction.

I would like to relate to you a happening as it relates to the delivery room nurse in Bill 57. Specifically, I would like to address the limitation on controlled acts, as set out in the bill, as it relates to the care of a labouring patient.

A woman walks through the door, obviously in great discomfort. I greet her, put her in a room. I check the foetal heart, assess, by hands-on manipulation, foetal position and the state of contractions. She tells me she feels like pushing. She would like an epidural. She asks me if she is in labour. She wonders if her baby is okay. She ruptures her membranes and the fluid is a dark green colour, normally clear.

What am I to do? If Bill 57 is passed, I cannot do any of the above as that would constitute management of labour. You have restricted me from examining her cervix until I get an order. Too bad the physician and/or qualified person is stuck on the elevator. I cannot answer her questions because that would be considered communicating to the individual a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual, etc. I cannot apply a foetal heart monitor for assessment as that constitutes a form of energy. As an experienced nurse I know the patient needs all of the above, along with verbal reassurances. Somebody please check the elevator.

The baby has delivered. She has difficulty breathing. She needs suctioning. Where is that qualified person when I need him or her? Too bad I cannot use my years of experience with neonates to give fast, effective needed care.

If I had gone ahead and applied the foetal monitor, if I had checked for dilation, if I had told the patient she was in labour and the amniotic fluid was off-colour, or if I had suctioned that baby, I would have been doing what I feel is giving safe and compassionate care to a labouring patient.

If Bill 57 is passed, I will be scrutinized not only by my employer and the college, but by any other regulated health profession that may feel I have overstepped my bounds. Based on this one small example, I find it difficult to see how you feel this bill is for the protection of the public and ensures the system operates with maximum efficiency.

In conclusion, I would like to say: Any decision made affects the quality of care. Therefore, all nurses must be made accountable for their decisions. By failing to license my scope of practice, you are subjecting my patients to increased fragmented care. The proposed legislation has failed to grant me the right to perform controlled acts independently.

1150

Therefore, you have defeated the objective of this legislation: the provision of high-quality care, operation of a system with maximum efficiency and protection of the public from unqualified, incompetent and unfit health care providers.

To invade our practice, to put limitations on what we are already doing, what we feel is part of competent and compassionate care, is unthinkable. I would like you to think of nurses as productive assets of the health care system.

Let us continue in that role to ensure the public do receive safe and competent care.

At this point I would ask you to consider my written submission regarding the Midwifery Act. I do believe in the right to choose an alternative method of childbirth, but just as firmly, I do believe that midwifery should be a speciality of nursing just as obstetrics is a speciality of medicine.

I welcome any questions you may have and I thank you very much for this opportunity.

Mr Beer: Thank you very much for your presentation and in particular for the examples that you set before us because, as is often said, we are laypeople and that can be helpful in seeing how you actually work. I wonder if I could ask the parliamentary assistant, in terms of the description of a number of the functions here that were set out where the witness has said that in her reading of the legislation she would not be able to do a number of those things, is that in fact the case in the way the drafters of the legislation intended that? How would those situations be handled?

Mr Wessinger: In general, I will answer the question by saying that I think the legislation permits those acts, but I will ask the ministry staff just to do it in detail.

Mr Burrows: A number of the situations that were described were emergency situations. If you look at Bill 43, section 28, you will find that it reads, "An act by a person is not a contravention of subsection 26(1)"—which is the list of controlled acts—"if it is done in the course of, (a) rendering first aid or temporary assistance in an emergency." So, for anyone, be he regulated or unregulated, there is a blanket provision for emergency situations.

Second, in the institutional setting we do have standing orders and protocols which can apply in which there is an agreement that in a certain situation, the professional team will behave in a certain way.

Third, there is specific delegation permitted and we have heard with previous presenters that issue discussed. I would also like to point out that nursing presently does not have a licensed scope of practice. Nurses under the Health Disciplines Act are treated differently than the other professions under the Health Disciplines Act. The other professions are licensed; nurses are registered. In the new scheme no profession will have a licensed scope of practice. Rather the only thing that will be controlled will be the specific potentially hazardous acts. I would like to clarify that nurses will have the same regulatory system as all other health professions.

Mr Beer: If it is made clear in terms of the work of the committee in the final passage of the legislation that you can do those things and are able to do those things, would that then meet the concerns that you have raised here? We have heard a lot about standing orders and protocols. Are those workable, effective, in terms of the kinds of things you can do?

Ms Conlon: In the case of standing orders, no. They are not an effective way to deal with this. We have used standing orders in our institutions and a lot of institutions are eliminating the use of standing orders.

Number one, it is very easy to just pick out number three, four, five and six of standing orders 1 through 20 and

apply it to this patient before walking into that room and doing an individual assessment of that patient and figuring out exactly what his or her needs are. So you are eliminating the individualized care by encouraging the use of standing orders.

Number two, working in a teaching facility, we have found that we work with clinical clerks, interns, every level, physicians who do not understand the significance of some of those standing orders that have been written. Therefore, we found that we could not use them. Even in an emergency you still have to have the authorization to use that standing order. You still have to phone someone to get the okay to use the standing order you have, and that is without anyone seeing that patient. I think what we would lose is the individualized assessment of the patient by getting back to the using of standing orders.

Mr Owens: Further to Mr Beer's question around standing orders, other members of your profession as well as your association have raised the concern around physicians refusing to retroactively sign for the order. Have you personally or do you know of any of your colleagues who have in fact been placed in that position where a physician has refused to retroactively sign?

Ms Conlon: Yes, I have on frequent occasions. You will be walking down the hall; they will say: "Yes, that's okay. Do that." You will write the order down or you will take the chart to them personally and you will stand in front of them and you will say, "Please write that order." "I can't remember when I wrote that order. There's no way I can sign this." It happens to me. In 19 years it has happened to me on a very frequent basis.

When I worked in a outpatient department, I was constantly on the phone getting orders for the things I was doing.

By the end of my time in there, all they were saying was, "Oh, no, it's Barb again." But they were giving me the orders I wanted. But yes, we do run into circumstances where they will, because they might not be able to see you for an hour or two after that order or to get the order signed and then they will say, "Barb, I don't remember telling you to do this." We have run into serious circumstances with that.

The Chair: Thank you very much for your presentation before the committee. We would encourage you, if there is any additional information you think would be helpful, to submit it in writing through the clerk. We thank you for appearing today.

Ms Conlon: Thank you very much. Have a good afternoon.

The Chair: I have some housekeeping issues for members of the committee. First of all, we would ask that you check out of the hotel over the noon hour. Bring your bags here. There has been a change in flight time for those who are flying out after the hearings. We will be leaving the hotel at 4:45 for a 5:25 flight which will arrive in Toronto at approximately 6:05. Please make a note of that and inform anyone who needs to be informed of that change, but we will be leaving the hotel today after the hearings at 4:45.

The most important item is that normally the committee meets in the afternoon at 2 pm. However, today we have a delegation appearing at 1:30. I would ask you to note that so we can begin the hearings as scheduled promptly at 1:30. The meeting now stands recessed until 1:30 pm.

The committee recessed at 1158.

AFTERNOON SITTING

The committee resumed at 1330.

IAN GALBRAITH

The Chair: I call Ian Galbraith. You have 10 minutes for your presentation. All members have received your written submission. We would ask if you would leave a few minutes for questions at the end.

Mr Galbraith: Thank you for the opportunity of speaking before the committee this afternoon. My name is Ian Galbraith. I am a registered nurse currently employed on the regional rehabilitation unit at Parkwood Hospital here in London. I am an active member of the Ontario Nurses' Association and am known to several of the committee members.

I am submitting this brief from my own perspective, but it may appear in many areas that it is in harmony with what you have already heard from the Ontario Nurses' Association, other ONA members and other staff nurses. I also note that it is in harmony with some of the recommendations of the College of Nurses of Ontario and the Registered Nurses' Association of Ontario brief that has already been submitted to you. This is not coincidental. The ONA presentation has only echoed the concerns that we hold as day-to-day practitioners of nursing. I urge you to review in depth their lengthy document.

Nurses in all cases are working to improve the overall health of patients. Nurses are the only professional group who are not interested only in some small aspect of patient care but are interested in the whole person and the continued improvement of health and health promotion.

I would like to recommend a book to all committee members by Sarah Jane Growe called *Who Cares?* It is an excellent book and highlights the ongoing issues that are occurring in nursing and in the health care field.

Though I am generally in favour of the government's plan with this proposed legislation to allow the general public the widest possible choice in choosing who should look after their health care, I quite simply have many questions and fears that I see with these acts as they are proposed.

It should be noted that nurses are in a unique position today since they now are under the Health Disciplines Act. We are in a triple jeopardy situation, being answerable to our clients, to our professional body and to our employer. If an employer or a manager orders a nurse to do something that is unprofessional or unsafe, the nurse is caught in a bind. To not do so risks charges of insubordination or dismissal; to do so runs the risk of sanction by the college of nurses.

Labour law has no mechanism for professionally sanctioning unprofessional or unreasonable actions by nurse administrators, educators or researchers. Should a nurse administrator knowingly employ an unsafe nurse who is repeatedly doing unsafe acts, the administrator can receive no direct sanction from the college of nurses. In the recent past here in London a nursing director had been repeatedly warned that a nurse was unsafe and unprofessional, and yet she did nothing. It was only after a gross violation that the

higher management stepped in, fired the nurse and then contacted the college of nurses. The nursing director, who had been aware of the situation for months, was untouchable by the college because she had done no direct patient care.

In my brief I also cite another example to show why we, as nurses, are asking for the inclusion of nurse administrators, educators and researchers under the nursing act so that they can be fully accountable to the college for their actions and their practice.

With regard to the licensed acts under Bill 43, I believe the legislation is taking the wrong tack with regard to licensing and the scope of practice of professionals. Instead of licensing the profession of nursing with a defined scope of practice, this legislation will allow anyone, no matter what his qualifications, to provide nursing care or treat a health condition for remuneration as long as he does not call himself a registered nurse or a registered nursing assistant, and does not perform a licensed act as defined in the RHPA, Bill 43 and Bill 57. This differs definitively from what is law in British Columbia and Nova Scotia, where the nursing scope of practice and the name "nurse" is protected.

The RHPA is not going to protect the public from unqualified or semi-qualified persons performing nursing care where it is not covered by the RHPA but is now in our scope of practice.

In my brief, I have highlighted several areas of my concern with the licensed acts. If I can highlight just one example, I would like to refer to page 5, the example of a patient who is newly admitted with a new tracheotomy. Should I have to wait for a doctor's order to suction that tracheotomy with a catheter? Even if an order has been written? Even if the chart reads, "Trach care QID+PRN," meaning four times per day or as necessary, and "Suction QID," meaning four times per day? This is taken verbatim from a chart.

What happens on the fifth time that patient needs suctioning? Do I wait, call the doctor, wait for a return call and watch the patient choke or start to drown in his own secretions? Or do I perform suctioning without an order and risk the sanction by the college of nurses for performing a licensed act beyond what the order now reads? Right now, I perform the suctioning because it is within my scope of practice, but after the RHPA, it is not. Who will decide what a qualified person is and who also will decide what constitutes an emergency?

As a committee, you may feel I am an alarmist in questioning these many potential traps and dangers found in the proposed acts. I do not feel I am being an alarmist but pointing out where the legislation is flawed and open to too much interpretation or question.

It has been suggested that local hospitals and agencies have standing orders or should have standing orders to cover nurses over the cracks in today's legislation, or those with the RHPA. I have cited from my own hospital manual, which states that there are no such things as standing orders in the hospital except in three very specific areas.

Finally, why do nurses have such apprehension surrounding the proposed acts and the areas that we practise in presently, which will be out of our sphere of practice with the RHPA? Some of that flows from the heavy-handedness of the present college of nurses and its current practices. It only takes a small complaint for a nurse to find herself or himself before the discipline committee of the college fighting for his or her certificate of confidence.

This may sound ridiculous, but if you refer to appendix A in my presentation, you will see that last December a nurse was called before the disciplines committee, having already passed through the complaints committee of the college, because he had overdue hospital library books. If overdue library books can take one before the discipline committee of the college, then I question whether performing an act once too often, or bordering on the edge of an unauthorized licensed act, surely would. To face a \$25,000 fine or six months in jail for suctioning a patient five times in one day is truly scary for any nurse.

I have made a number of recommendations in my brief. In summary, I support the thrust of the bill to open the health-care system to the widest amount of choice for the consumer. My recommendations are based upon what I have experienced and what I have heard from other working nurses today. With the recommendations I have made, and those of the Ontario Nurses' Association to you, the standing committee on social development and the present government can make a good health system even better to work in and to be a consumer in.

Mr Hope: I would like to focus on your recommendation A, if you do not mind looking at that. I hold particular interest with the triple jeopardy that you have been bringing forward and we have been hearing throughout. You are saying to bring them under the college of nurses. What if they were under a separate administration or a separate accountability part of legislation? Would you want them part of the college or should they be a part of a separate one that holds accountability—making sure enough staff is there, making sure that when there are budget cuts that they are not jeopardizing a patient's health? Should they be accountable to a different body other than the college of nurses? Because you have not only the nursing administrators, but you still have another tier above that.

Mr Galbraith: Yes, that tier above. In my brief I do discuss to some degree the point of going beyond and having other people brought under the nurses' college. It is very clear that nurse administrators, educators and researchers could be put under the college. I also recommend that other people who are administering other professionals be accountable to someone. I am not sure exactly who that should be, whether you should create a third college, whether you should create some kind of other body. I think also if someone is in charge of, say, a physical therapy department but is not a physical therapist, or is in charge of a nursing department and is not necessarily a nurse, yet a nurse has to be answerable to them, then that person should be accountable also.

Mr Hope: That is really our particular interest. You are trying to get the weight off your shoulder by making

other people accountable, but then there are other people here who have to answer to somebody else. We had to make the whole system accountable. That is why I posed that question.

Mr Galbraith: Accountability is important, but as it stands now, the only one who is accountable to the college is the person who is actually doing the hands-on care.

The Chair: Thank you very much for your presentation. We appreciate hearing from you today. I know that you are aware that if there is anything further you wish to communicate to the committee that you can do so in writing at any time.

1340

INTERFAITH PASTORAL COUNSELLING CENTRE

The Chair: I call the Interfaith Pastoral Counselling Centre and the Presbytery of Waterloo-Wellington. You have 20 minutes for your presentation. I would ask that you begin by introducing yourself to the committee for the purposes of Hansard, and leave a few minutes at the end, if you would, for questions from committee members.

Mr Henderson: My name is John Henderson. I am the executive director of the Interfaith Pastoral Counselling Centre in Kitchener. I am also a member of the Presbytery of Waterloo-Wellington and the Presbyterian Church in Canada. So I am here wearing two hats today and hopefully I can weave them through.

I am not familiar enough with the legislation to offer a lot of constructive suggestions. Rather, I would like to simply indicate some concerns that I have, coming from where I do, as a clergyman and also as an executive director of our centre.

Interfaith was established in 1968 as a centennial project of Trinity United Church in Kitchener. The purpose was to provide qualified counselling to people, regardless of the ability to pay. While rooted in the Judaeo-Christian ethic, the commitment was to offer counselling that respected and honoured the value and belief system of a multicultural and multifaith community. Hence the name Interfaith. Second, its purpose was to train counsellors. Initially, much of the training was taken by clergy, but quickly expanded to include others in the community and surrounding area. Over the years, with informed and visionary leadership, Interfaith has grown in both its counselling and training programs.

In its earliest days, Interfaith's training program cultivated connections to Wilfrid Laurier University through the Waterloo Lutheran Seminary. Today, Interfaith offers 11 academic courses at the master's level at Wilfrid Laurier University. In 1987, Interfaith was the first training centre in Canada to be accredited as a teaching centre by the American Association of Marriage and Family Therapy. The University of Guelph is currently the only other such accredited centre in Canada. Interfaith relates to AAMFT through the Ontario Association for Marriage and Family Therapy. As well, Interfaith has been accredited as a training centre for 11 years by the Canadian Association for Pastoral Education.

Currently we have six professional staff, all of whom are clinical members and approved supervisors of

AAMFT. The training program is two years in duration and has 26 interns. To qualify, interns must be able to work clinically and academically at the Masters Level. We have a pre-intern program that has 127 students enrolled. Interns strive to become clinical members of the AAMFT. This membership represents, at a minimum, a master's degree in a behavioural area, 11 academic courses in marriage and family at a master's level, and a minimum of 1,000 hours of marriage and family therapy conducted under approved AAMFT supervision.

The other hat I am wearing today is that of clergyman. For 20 years, from 1968 to 1988, I was pastor of four congregations. For the past 19 years, I have been a member of the Presbytery of Waterloo-Wellington, whose boundaries correspond to those of the Waterloo-Wellington counties.

One of my major interests has been the recruitment, processing and screening of candidates for the ministry. As you may guess, my long-time interest has been in the pastoral relationship of pastor and parishioner. It was early in 1973 that I personally sought out training at Interfaith counselling, and completed that training in 1980.

Recently, my presbytery requested that I make representation to you regarding Bill 43, the Regulated Health Professions Act. My ministerial colleagues are dismayed by their understanding of the proposed legislation.

From a legal opinion, I understand the following: I assume from another presentation you have already had this documented by Morris, Rose, Ledgett, barristers and solicitors in Toronto.

1. The Regulated Health Professions Act seeks to replace the prohibition of the practice of medicine without a licence contained in the Health Disciplines Act by a series of controlled acts, which only a medical practitioner—or, in the case of a few of these acts, some other regulated professions—is authorized to perform.

2. The act provides for the establishment of a college for each of the regulated health professions. It defines the scope of practice of each of the professions by setting out a list of controlled acts which a member of that profession is licensed to perform.

3. The legal opinion states that a difficulty has arisen with respect to the medical profession in particular. The act has attempted to define the practice of medicine by reference to a series of controlled acts, including in paragraph 26(1): "Communicating to the individual or his or her personal representative a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the conclusion."

This diagnosis clause is intended to prohibit anyone who is not a medical practitioner, except for members of other regulated professions such as dentistry, psychology and chiropractic, who can diagnose within a restricted area, from communicating a diagnosis to an individual.

4. By attempting to broadly regulate the diagnosis of diseases, disorders and dysfunctions, the clause potentially proscribes the legitimate exercise of the practice of a large number of unregulated health care practitioners. The legislation potentially includes within its scope a number of

activities previously legitimately performed by unregulated practitioners. There is no indication in the act that the intention of the legislation is to prohibit unregulated practitioners from communicating assessments in accordance with the distinctive training and explanatory framework of the disciplines in which they have studied and trained, yet the vagueness of the terms "disorder" or "dysfunction" as "the cause of the symptoms" could very well likely lead to such an outcome.

5. The limitation that the diagnosis must be "in the course of providing health care services" does not provide effective protection to an unregulated practitioner. Health includes mental health, and therefore the counselling that marriage and family therapists and ministers provide could conceivably come within the bounds of this restriction.

My concern also is with sections 36(1), 37(1) and 38(1) and (2) of the act, which outline the liability of employment agencies, responsibility of employers and the responsibility of directors of corporate employers. They outline the liability of \$25,000 and, in the first instance, imprisonment for a term of not more than six months.

The Regulated Health Professions Act makes marriage and family therapists, the staff and board of directors of my centre, Interfaith Pastoral Counselling Centre, and all clergy potentially liable under this proposed act. At least, this is how my people are responding to it. I and many of my colleagues find this distressing and dismayed.

Recently, I was part of a coalition in Kitchener-Waterloo of eight counselling agencies that provide counselling to clients on welfare. Among our counselling, we do clients on welfare and income assistance. We met with four area government politicians who praised us for providing counselling services to the needy, the disadvantaged and those who have no advocate. We were lobbying in this instance for more government funding, as government funds fall short and we have to fund-raise to provide this service. In the next breath, when questioned about the proposed act, they responded that it was going to go through as is. May I be forgiven for finding this attitude cynical. In 1989, these agencies provided 31,899 hours of counselling to those on social assistance. This is a statistic taken from a study by the Waterloo Region Social Resources Council, June, 1991.

My submission today is more of a protest and a request to make the proposed act less vague. If, as the legal opinion states in 1, 2 and 3, which we have gone through, that the intention of the act was to address the medical profession, then could that not be made crystal clear and limited to that? Otherwise the proposed act appears to discriminate against the legitimate exercise of the professions of marriage and family therapy and its training programs, and our province's clergy. From where I and my colleagues sit, we feel the proposed act isolates us, points a finger at us, identifying us unnecessarily as liable to prosecution. To allow the courts to make decisions on our liability in this manner is financially unwelcome by us and would sow seeds of resentment towards our elected representatives. I contend that nothing is gained by that. That is all I have to say.

1350

Mr Beer: Thank you for your presentation. I think, as you are aware, this issue has come up fairly frequently, and it is also fair to say that there are different interpretations as to whether in fact the clauses that you mentioned do what you think they might, but I think as a committee we are seized of the fact that there are people who think it might do that and so we are concerned about that one.

The Coalition of Unregulated Practitioners did put forward a number of possible changes and I was wondering whether you and your organization had seen those or were part of that and whether you had any particular preferences that included exempting clergy or rewording the clause.

Mr Henderson: I just received this, actually, two days ago, so I have not had time to digest it. I have not been actively part of the coalition in terms of attending meetings.

Mr Beer: That is fine. I think there are some proposals there, and I would simply say if there was something there that you thought met the arguments and the concerns that you had, you could perhaps let us know in writing and that could go with your brief.

Mr Henderson: Sure.

Ms Haeck: Thank you, Mr Henderson, for your submission today. In a way, I am following up on what Mr Beer has already questioned you about. While the Coalition of Unregulated Practitioners has put forward a clause—and I have also heard from other clergy in my own riding who share a similar concern—I do want to pose a question to you with regard to clause 28(c), which has been viewed very favourably by the Christian Science denomination, which came before us yesterday, which states, “treating a person by prayers or spiritual means in accordance with the tenets of the religion of the person giving treatment.” In fact, this was an exemption for those people who use spiritual means. Do you feel that is adequate protection to continue counselling within the church environment?

Mr Henderson: Off the top of my head, I do not think so. I think your reading was, if I remember correctly, those who use your prayer.

Ms Haeck: Yes, “An act by a person is not a contravention of subsection 26(1) if it is done in the course of,” and (c) does mention treating the person by prayer or spiritual means.

Mr Henderson: That is too narrow, in my mind, as an exemption.

Ms Haeck: I see. Thank you very much for your opinion.

Mrs Cunningham: I guess my concern is with your main reason for being here. Your input is similar to the input of your colleagues across the province, Reverend Henderson, and I would just like to say that certainly we are sitting here to make changes, where changes are appropriate, and to make recommendations as a result of the hearings of this committee. I would hope that would be your intention as you go back to your community to let your community know that there will be changes as a result of these public hearings. I am sorry that you were told

otherwise, and I certainly hope that my colleague Elizabeth Witmer was not one of the people you met with.

Mr Henderson: No. By government I meant elected to government, the people in our area we met with.

Mrs Cunningham: Perhaps the government representatives could discuss that with their own colleagues. There is nothing worse in these public hearings than to come here thinking that people are not listening. All of us here are here to listen and make changes as we feel appropriate. I am certain that the Chairman will be making recommendations on behalf of the committee here as a result of these hearings.

Mr Martin: I appreciate your coming before us today. Historically, churches have spoken up on behalf of the people they serve, although so far in the numbers of deputations that we have heard from church groups I have not detected any real effort to hear from the people you serve. The intent of this legislation is to enhance delivery of services, but it is also very much to protect the public, and some of the things that are in here are to make sure that the public in fact is being protected. I am wondering, have you spoken to any of your colleagues about what they are getting back from their parishioners regarding this legislation so that we might somehow be enlightened re their perspective on all of this?

Mr Henderson: Only more from the clergy who—as can be expected, there are a lot of people who are not quite familiar with the details, about the vagueness, and so there is a lot of hysteria that can come out of that and some concern about the quality of the relationship between the pastor and the parishioner and what the pastor will or will not be able to do.

I think all of us—at least, the people I work with—are quite concerned that there be accountability within the professions. In our agency, for example, we have developed a pamphlet which we give to all clients that specifically mentions that if they have some uneasiness around business relationships, sexual relationship, etc, they are to contact our director of counselling, who is a female. We are trying to be sensitive to what is happening in our society right now in upholding a fairly substantial ethical viewpoint. We have our code of ethics, for example, in our waiting room. I think clergy are quite concerned about this as well, perhaps in reaction to what has been happening in the last number of years, but still that is very much there.

In a sense we support, I think, what the intent of this act is attempting to do, but I am wondering if there is not more requirement upon each body to regulate itself, and if it is not going to regulate itself, that is when the civil authority moves in. I think in the marriage and family therapy field we are fairly strict, the Ontario Association for Marriage and Family Therapy anyway. If I have what we call a dual relationship with a client within two years after I have terminated counselling with this person, I lose my credentials. I think that is fairly strong, and that has been there for some time, and I support that. I think that is excellent. So there is regulation going on among us, and I am wondering if we could not build more on that.

Mr Hope: Just to elaborate a little more on some of your report talking about whether it is worth while coming

here and making presentations, I will refer you to the opening remarks of the minister when these hearings started that she was open to change, because we needed more of a consultation process as this thing has taken place since 1982. I guess how much of it will be open will be subject to discretion, but a number of the clauses that are coming forward to us the minister understands, especially your specific dealing with the social service aspect of it and the diagnosis clause. Yes, we are definitely looking at that, and I think we have a non-partisan committee here. Most of the time we have partisanship, but I think this committee itself is working on a non-partisan basis to make sure that we can rectify the problems in the health care system. That is just to reassure you.

Mr Henderson: Good. Thank you.

The Chair: Thank you very much for your presentation today. I appreciate your coming before the committee. If over the course of the hearings there is additional information that you think would be helpful to the committee in its deliberations, please feel free to communicate with us in writing. For the information of everyone here, the expectation is that clause-by-clause examination of this package of legislation will begin after the House resumes, which will be after September 23. Thank you very much.

1400

UNIVERSITY OF WATERLOO
SCHOOL OF OPTOMETRY

The Chair: Next is the University of Waterloo school of optometry.

Dr Cullen: I am Professor Anthony Cullen, and I am associate dean of science and director of the school of optometry at the University of Waterloo. In addition, I sit on the Ontario Council of University Health Sciences. I have been a consultant to the World Health Organization, the United Nations, the American army and to the National Research Council of Canada. My area of expertise is physical energy phenomena effects on the eye. Accompanying me today is Dr Graham Strong, who is an internationally recognized authority in the rehabilitation of the visually handicapped. He will describe to you, should you wish, the many diseases for which there is no known medical or surgical treatment which we are able to diagnose and treat. Also accompanying me today is Dr John Flanagan, who is also a world-recognized authority. His area is advanced diagnostic techniques of the eye, and his special area of expertise is in the early diagnosis of glaucoma. His research is funded by the Medical Research Council of Canada. Since at an earlier hearing you were supplied with misinformation concerning glaucoma, he will happily be able to supply you with the difference between diagnosis of glaucoma and mere screening, which can be performed by technicians or lay members of the public.

I would like to thank the standing committee on social development for this opportunity to present the concerns of the University of Waterloo school of optometry. Certain aspects of this tandem legislation under consideration would seriously compromise our ability to provide contemporary, high-quality optometric education and clinical services in the province of Ontario.

As many of you may know, the University of Waterloo offers one of only two programs in optometry in Canada. The other is at l'Université de Montréal. The majority of optometrists in English Canada are alumni of the University of Waterloo. If legislation regulating the optometric profession in Ontario is retrograde or lags behind that of other provinces, our ability to educate optometrists within Ontario would be the most constrained and restrictive in North America. To provide interns with the requisite clinical exposure for a competitive optometric education, it would be necessary to arrange supplemental clinical teaching placements outside Ontario in other provinces or even in the United States. This would create an additional cost for optometry students and their families. In addition, there will be little incentive under such restrictions for University of Waterloo optometry graduates to remain in Ontario.

The executive summary to the Regulated Health Professions Act claims that the general scope statement "will guide educators when they design and update curricula." Were we to accept the proposed scope of practice and authorized acts of Bill 60, radical changes would be required to eradicate portions of our current curriculum. We have provided you in table 1 with details of our current curriculum. This would, in addition, have serious repercussions not only in Ontario but across Canada, and would potentially jeopardize our accreditation as a school of optometry.

The optometric education program produces an externally verified level of expertise that extends well beyond the proposed scope of practice for Ontario. Doctors of optometry graduating from the University of Waterloo are the best-qualified primary care—and I emphasize "primary"—professionals to assess, diagnose, treat and prevent diseases, disorders and dysfunctions of the eye and the visual system.

The proposed limitations to the existing scope of optometric practice represent a clear contradiction of the Ministry of Health's own assistive devices program policy, which we have provided for you in the brief, and Revenue Canada's policy, which recognizes optometric expertise in the diagnosis of diseases of the eye and visual system.

Through regressive semantic manipulation, the proposed scope of practice would unfairly diminish the current activities of Ontario optometrists. The only remaining community resource outside of the major cities for Ontario residents would be the general medical practitioners. They are ill-equipped to diagnose and manage diseases, disorders and dysfunctions of the eye and the visual system.

The standards by which the controlled acts have been delegated to medicine have been in accordance with the highest common multiple, whereas for optometry it reflects the lowest-common-factor approach. Few physicians are capable of performing each and every one of their controlled acts, while most optometrists are capable of greatly exceeding the limitations of their controlled acts. This approach is unfair to the legitimate majority of optometrists in Ontario.

By stifling the legitimate scope of optometric practice, the proposed legislation fosters underexploitation of the established excellence of our optometric education program and an underutilization of the established clinical prowess of our graduates. This situation is unfortunate for the people

of Ontario who rely heavily on the availability of full-scope optometric services within easy reach of their home. The individual people in the province will ultimately pay a premium for less accessibility and inferior health care services.

The issue to be considered is demonstrated competence in the provision of important health care services to Ontario residents. There is no room for polemic mediation of these issues. Optometrists are amply qualified to continue to provide extensive eye and vision care services to Ontarians. They are accessible to all provincial residents. The quality of their services is recognized by the public, by government and by academic and scientific communities. They have consistently demonstrated a responsible and co-operative interaction with government agencies and with other members of the health care team. In the region of Waterloo, there is no conflict between optometry and ophthalmology. We respectfully suggest that the subject of this legislation is health care, not medical care.

1410

The Chair: Thank you very much for your presentation. Question, Mr Wilson?

Mr J. Wilson: Perhaps it is more of a clarification from the parliamentary assistant. Given this evidence and other evidence before us previously, why in the Optometry Act were optometrists not given the diagnostic controlled act? Could we have the ministerial reasoning behind that?

Mr Wessinger: I will refer that to staff, although it should be noted that they are given some diagnostic aspect with respect to dysfunctions of the eye. I will refer to staff the reasoning for the limitation.

Mr Burrows: Not having been a member of the review team, I cannot properly account for every particular piece of work it did. However, suffice it to say that the proposed act, which is based upon their findings, which is the result of considering all the information that was presented to the review over a period of six years, not only by the profession of optometry but by ophthalmologists, opticians and consumer groups as well, taking everything into account, in the wisdom of the review the decision was that the scope-of-practice statement accurately captured what optometrists do. That statement reads, "The practice of optometry is the assessment of the eye and vision system and the diagnosis, treatment and prevention of vision and ocular motor dysfunctions of the eye."

Since the receipt of the report's recommendations, there has been extensive discussion between ministry staff and not only representatives of the association but the College of Optometrists as well. We have also consulted with other interests in the eye care field for their opinions, and we certainly made considerable progress over that time in terms of coming up with possible alterations and options for changing that statement. However, suffice it to say, we could not obtain consensus.

One of the things I believe will happen before the hearings are complete is that this committee will hear information from some of these other interests with respect to who does what in the eye care field. I really have nothing to add. The statement did capture, in the opinion of the review, what optometrists do. We have heard evidence to the

contrary here and in other presentations, but I believe you will hear additional comment from other parties in the field of eye care before the hearings are finished.

Mr Beer: I do not want to put words into your mouth; I want to just make sure I am clear. In the concerns you have as to how in your view your scope of practice is being limited, I take it that it is through the ophthalmologists who are saying their practice is different and yours should be limited, and that is the crux of the issue. I want to make sure and ask you, is that correct? Then with that, you mentioned the issue of glaucoma and it struck me that was probably an example where you could inform us as to how you would deal with that and why in your terms you were quite competent and capable. So there are two parts to that; I am first just wanting to be certain where the conflict is and then, second, is the glaucoma example a good one to describe to us something you do now that you could not do under this act?

Dr Cullen: Initially I would like to point out that ophthalmology is not a regulated discipline under the act. It is under the umbrella of medicine. We certainly have problems that any physician who may have had very limited education in the eye is permitted to do any act. A solution to this may be to subdivide medicine into specialties.

The ophthalmologist is a specialist. In the United Kingdom, where I originated, they remain specialists. Unfortunately, in Ontario many ophthalmologists practice primary care. Very few do in the region of Waterloo, which is why we get on very well. The problem is using highly expensively and highly trained ophthalmologists to provide primary care. It is illogical.

With regard to glaucoma, I would defer to Dr Flanagan.

Dr Flanagan: Glaucoma does provide a good example. One of the dangers of getting into a conversation specifically about glaucoma—I would like to point out other aspects of the report and the information provided that go through a whole series of different diseases. If you go to page 14 of the report we provided, glaucoma is specifically listed there. The way we tried to do it is approach it somewhat academically and give you quotations from refereed medical journals that we all publish in, along with the medical profession, to point out from surveys and what have you about who does the diagnosis of these different diseases.

The emphasis is on primary care, in that glaucoma is largely asymptomatic in its early stages, which is why optometry plays such a big part in diagnosing glaucoma. I think it is still this problem of diagnosis, in that with the act as it appears to be presented to us we are not deemed capable of making the diagnosis; that means we are able to assess or to screen for, which means that you make a referral in ignorance. Glaucoma is one way your referral in ignorance would go to the same person that you would refer to even if you diagnosed the condition, which we all believe we do. But there are many other conditions where we, having made an accurate diagnosis, save the OHIP system a great deal of money by referring to the appropriate specialty. One of the points that we really must make is that not all of our referrals go to ophthalmology. We refer

to a great many other specialties, and if we are not allowed to diagnose that ability is taken away.

The other aspect is counselling, and this would come under glaucoma too, that the restricted act is one of counselling once a diagnosis is made. That is the thing that we take great pride in, that we certainly spend a lot of time doing. In fact, I would suggest that ophthalmology very often uses our services to provide that counselling, and that will be taken away. Most ophthalmologists, like the ones we deal with in our area, who, as has been said, we get on perfectly well with, do not necessarily feel it is the best use of their time to provide the counselling services, knowing that we can provide those services. Under the new act, we would not be able to do that, so that is another side issue of the whole diagnosis issue.

But it is very clear that the general practitioner, who would be the primary eye care clinician if this act goes through, in the majority of Ontario does not have the necessary equipment or skills to diagnose glaucoma in the early stages. This is not an antimedicine statement. We consider ourselves part of the medical model, as does medicine consider us part of the medical model. So we do not see the conflict. We do not see ourselves as an alternative to; we are just providing something that is not otherwise provided. Really, the discussion here is merely for recognition of what we in fact do. We are not even asking for what we consider our scope of practice to be broadened, which an awful lot of people would want to do in this sort of environment. We now feel we are fighting simply to be recognized for what we have done for years, and which we do very well.

The Chair: I have a request from the parliamentary assistant to clarify.

Mr Wessenger: I would just like to indicate to you that in the act there is no restriction on your doing a diagnosis. The only restriction is with respect to the communication of that diagnosis to the patient. There is also no restriction on your communicating that diagnosis to an appropriate specialist. So there is no restriction on what you say you normally do. Of course, if you even go further, there is no restriction on communicating the results of an assessment to the patient.

Dr Strong: My name is Graham Strong. There seems to be a lot of misunderstanding about what in fact a diagnosis is. The committee seems to believe that a diagnosis is—that out of an array of naming of disease, there is one that applies to the particular presentation. There is that sense of what a diagnosis is, when in fact a diagnosis is technically a hierarchical process, as reflected in standard systems of diagnosis or computerization of diagnosis. There is an evolving level of specificity. I think it is in that spirit that medicine is given this power to diagnose. A general practitioner can in fact diagnose sophisticated neurological disorders to a certain level of specificity. When that is referred, there is further qualification and clarification which leads to a more precise, if you want, diagnosis.

The initial act is one of diagnosis. The initial act that an optometrist provides, the initial service, is one of diagnosis, and it seems to me that to invoke the expertise of

ophthalmology is really to be sidetracked into the level of specificity of that diagnosis in some instances.

Mr Johnson: I wanted to ask a question about glaucoma, seeing as we have a pre-eminent expert in optometry here, but Mr Beer's second question was my first question. I would like to pass to Mr Owens, if the Chair is agreeable to that.

The Chair: No, Ms Haeck is next.

Ms Haeck: I will defer to Mr Owens.

Mr Owens: The hand-off. Thank you, Madam Chair and colleagues.

We had a presentation from a group of optometrists and they indicated, I believe, that there are currently 27 states that allow the prescription of drugs by optometrists. If we were to agree to that request for amendment, as I understand it is being made, would that require a change in your curriculum, or are you already at the level where the prescription of drugs would be just an adjunct to what you are already doing?

Dr Cullen: There has been a change in the number, as Texas now approves the prescription of therapeutic drugs.

Mr Owens: So we are up to 28 now?

Dr Cullen: We are at 28 now. In that many of our students do their post-doctoral residency training in the United States, it is important that they be educated to function in that milieu. Therefore, our students are instructed in therapeutics, as you will see from our curriculum which we have provided. It is not our intention at this point in time to push for therapeutic drugs from the school, certainly. On the other hand, we have to be prepared should these things happen in the future with the natural evolution of the profession. For the question as to whether the change in the current proposed legislation would affect what we do, the answer is no.

The Chair: Thank you very much for your presentation. We appreciate your appearing before the committee today, and I know you realize that if there is any additional information you think would be helpful for the committee, that you will communicate that in writing through our clerk. Thank you very much.

1420

LONDON AND AREA ASSOCIATION OF OPTOMETRISTS

The Chair: I call the London and Area Association of Optometrists.

Dr Van Ymeren: Thank you. I am Dr Harry Van Ymeren, and I am president of the London and Area Association of Optometrists.

Dr White: I am Dr David White. I am the secretary of the London association.

Dr Van Ymeren: Ms Chairperson, committee members, ladies and gentlemen, thank you for this opportunity to present here before you.

We represent the London and Area Association of Optometrists. We are a local study group of 40 practising optometrists. We as a group provide an overwhelming majority of the vision care to the residents of this part of

Ontario. We have not been involved in the development of this legislation. We have no authority to either represent, educate, or govern our profession. Our only claim to authority is that we know what optometrists do for their patients. The reason we are here is that Bill 60 does not describe what we do in our offices on a daily basis. We wish to express our concern that the proposed legislation will materially interfere with our patient care.

To highlight our comments, I will describe briefly the standard optometric eye examination. Odds are high that most of you see an optometrist, but I hope to give you the doctor's perspective of what is happening. Then I shall illustrate how the proposed legislation will disrupt how we provide care for our patients.

What we do is in these guidelines, of which you all have a copy, the Guide to the Clinical Practice of Optometry. Guidelines such as these have been published by the College of Optometrists of Ontario for nearly 20 years. The college has the statutory job of protecting the public by regulating the profession of optometry. Revisions such as this recent one are the result of input from both experts and from those of us in the field.

Pages 11 and 12 describe the most frequently rendered optometric service, the oculo-visual assessment. The majority of my day is spent providing this service to my patients. As you will see from the introductory paragraph, the OVA, as we call it, has five components: a history; an ocular health assessment; a refractive assessment; an oculo-motor and sensory assessment; and finally an analysis, which is going on continuously throughout the case history and clinical procedures.

In the interests of time, I will leave the details of the first four sections for your later study. The history and clinical procedures component of the OVA would consume 15 to 45 minutes. This would depend upon the complexity of the case presenting and whether the patient has been seen before.

The analysis section is the one that would get completely fouled up with Bill 60. I must read the analysis guideline word for word so that you understand the thinking process that accompanies the optometric eye examination.

The purpose of the analysis is the delineation of problems and the formulation of management plans. It reads, if you refer to the manual:

"(a) An analysis is expected of the history and data collected to determine the presence or absence of ocular health problems, refractive problems, and oculo-motor and sensory problems. A problem is defined as any deviation from the usual state, condition, structure or function.

"(b) Delineation of problems is expected at the highest level which the data and the member's knowledge and understanding permit. It may not be possible to define a problem as other than an unexplained symptom. At other times, a problem may be defined as a related collection of symptoms and/or findings. At the highest level of understanding, it may be possible to make a specific diagnosis of a disease, dysfunction, or disorder.

"(c) The development of a management plan for each defined problem is expected. Management is always

expected to include counselling and, as needed, plans for further investigation, treatment or referral."

This is the "law" as it applies to optometrists. This manual is the standard against which ordinary optometrists are judged. It is not just our opinion of what we do for our patients; it is what under the present legislation we are legally obliged to do.

As you see in subsection (b), "it may be possible to make a specific diagnosis of a disease, dysfunction or disorder." We very often do. From subsection (c), you can see that the "management is always expected to include counselling."

Here are the problems:

1. Bill 60 would not permit the required diagnosis of a disease or disorder. It says I can only diagnose vision and oculo-motor dysfunctions. It is important; a dysfunction by definition describes a system that is anatomically and structurally normal but is not working or functioning properly. The diseases and disorders that we presently diagnose are not included in this definition.

2. The first authorized act would not permit the communication of a conclusion identifying a disease or disorder as the cause of a person's symptoms. It says I can only communicate a conclusion identifying a vision or oculo-motor dysfunction.

That, ladies and gentlemen, creates a ridiculous scenario. The best example of the situation created is one that you may have heard. A patient with cataract, which is easily diagnosable by any optometrist, would suddenly not be diagnosed. Cataract is not a vision or oculo-motor dysfunction. Cataract is a disease. Its diagnosis is made by a visual inspection of the crystalline lens of the eye using either an ophthalmoscope or a biomicroscope. We as optometrists diagnose cataract and then we assess its effect on the visual performance of our patients. We may refer this patient for treatment, ie, surgery, if the cataract is advanced. We would not refer this patient for a diagnosis.

Bill 60 as it stands would change what I do dramatically in this case. Since it is not a visual dysfunction and not an oculo-motor dysfunction, I could not diagnose it and could not communicate my diagnosis to my patient as I do now.

From reading sections 3 and 4 of Bill 60, it is clear that every condition that might be labelled as a disease or disorder must, if the patient is to be aware of it, be referred for medical consultation. That would triple the number of referrals—all unnecessary, not to mention inconvenient and distressing to the patient and very expensive to the health care system.

Let me give you two other examples. Many people get a little yellowish bump on the white of their eye. It is a pinguecula, an innocuous disorder requiring no treatment other than a dose of reassurance. Again, this is not a vision or oculo-motor dysfunction, so therefore I would not be permitted to make that diagnosis or to provide the necessary reassurance.

Many of our contact-lens-wearing patients develop symptoms of itching and mucous discharge. These symptoms can be traced to wearing a contact lens with a protein deposit. This problem is diagnosed as an allergic disease known as giant papillary conjunctivitis. The treatment is removal of the lens or the film on it, which is always

effective. Optometrists will be precluded from diagnosing this disease, from communicating their knowledge of it to the patient and from treating the problem by counselling on the appropriate action.

In conclusion, the authors of this bill cannot have understood the consequences of their writing. The scope-of-practice statement and the first authorized act in Bill 60 do not describe how optometry is practised in Ontario. Optometrists know what optometrists do. What optometrists do, they do responsibly. There has not been a single successful malpractice action brought against an optometrist in Ontario.

It is obvious to our group that the proposed scope of practice is grossly inaccurate. This error is a result of either a lack of knowledge of what optometrists do for their patients or it is an attempt by various groups to use this process here to narrow the scope of optometric practice. Either is totally unacceptable and I, and for my patients, hope this committee will recognize the serious flaw and ensure it is corrected.

1430

Mr Beer: Thank you very much for this submission and the accompanying document because, again, in trying to determine precisely what it is you do, what you do today and what it is in your view you cannot do—when the Ontario association appeared before the committee I was not able to be present. Are there specific recommendations around how you would see in Bill 60 the way the diagnosis is set out for you, what you can communicate? Are you saying you simply want to be able to communicate as it is set out in Bill 43, or that what is in your own bill should be expanded so it includes the kinds of examples like the cataract? Because clearly you are saying in paragraphs 1 and 2 of section 4 that it is limiting what you do today.

Dr Van Ymeren: Exactly. I think I understood your question. All we are saying is that presently we diagnose cataract and the legal interpretation of the—I am not a lawyer, I am just an optometrist. I read the act and look at what I do in practice and say, "Geez, this doesn't allow me to do what I'm doing today."

Patients come to me for diagnosis. They do not want to wait for six to eight months to get in to see an ophthalmologist if in fact the diagnosis is totally within my ability, and it certainly is.

Mr Beer: So there may be other wording around what is in your own bill which would capture those other points?

Dr Van Ymeren: I do not think I could comment on that. My expertise or authority is that I know what we do and I know that—

Mr Beer: And that is not defined there.

Dr Van Ymeren: I think there are better people to suggest what in fact would better describe our scope.

Mr Hope: I have particular concerns that you indicated whoever wrote this did not know what they were talking about. I guess my question would be to the parliamentary assistant and legal counsel. How did we come up with it? We have an accusation of no involvement, or the authors did not know what they were talking about, and I would like a little clarification on this.

Mr Wessenger: With respect to that question, legal counsel is not here to specifically advise. However, it was based on the review. The legislation was based on the recommendations of the review, so I think you would have to even go back beyond the question of legal counsel in drafting, you would have to go back to what the review recommended. That would certainly be the assessment by the review as to what the areas of jurisdiction were. I might have ministry staff add to that.

Mr Burrows: As I explained previously, one of the things we have done since the receipt of the review's recommendations—we know that the profession of optometry has concerns. Such things as the valuable service provided by the profession in screening, for example, in glaucoma and so forth go without question and no one is disputing those facts. In looking at options of potential wording, we have not been able to get agreement on what appropriate wording might be if there is something else that better describes what optometrists do.

Mrs Cunningham: I am going to ask the ultimate question. What do you think the appropriate process would be to come up with the appropriate wording that everyone does not seem to know should exist? I suggest you not say that you are not the one to come up with it.

Dr Van Ymeren: No, I can certainly tell you what I do today in practice and I can tell you that it is not well described, or it is not described at the present. Certainly we provide primary eye care to the majority of people in Ontario and that primary eye care involves diagnosis. It is not just screening. Screening would entail saying: "Yes, there is a disease; no, there is not a disease." I look at it and say: "It's a disease. Not to worry about it, we'll monitor it." I diagnose it and I communicate that to my patient. To suggest it is a screening is in fact an unbelievable oversimplification. It again illustrates, in my opinion, that nobody understands.

Dr White: I believe every patient who comes into our office expects a diagnosis. That diagnosis may be a tentative diagnosis, it may be an inconsequential diagnosis, but they expect a diagnosis. If we are not able to make that diagnosis, if we are not able to communicate that diagnosis, what are we doing?

Mr Martin: If in fact you are correct and we give you the benefit of the doubt here, my concern, coming from northern Ontario, is the delivery of service to the folks who live up there. Certainly, to limit your ability as optometrists to do your work in those areas where there are not the ophthalmologists would have a negative impact re access. Could you speak a bit about that?

Dr Van Ymeren: True, certainly there is more pressure on practitioners in smaller communities to service their patients more broadly, if you will. I practise in London and there are lots of ophthalmologists to refer to, yet I still make the diagnosis. The result of this would certainly affect your area more than London, I presume, just because you would be looking at an increased cost to the patients having to drive a long way to have an ophthalmological opinion.

It really just disrupts the normal relationship that practitioners have with their patients. Patients expect diagnosis, and to suddenly not allow that certainly is not the reason

for the scope definition. It is supposedly status quo and it definitely is not. But I could see your concerns with regard to a small town.

The Chair: Mr Hope, you had one further question?

Mr Hope: When I am listening to the conversation, certainly the professions were involved in the—what is it?—the blueprint through the consultation process. I am sure the professions must have been involved through this discussion process. When I hear a presentation like this saying somebody does not know what they are talking about, are we talking about age differential between what the old fashion and the new fashion may be? That is why I am uncertain. I am hearing a presentation that we did not know what we are talking about.

Dr Van Ymeren: I gave you two options as to why this is like it is. I think it is maybe a combination of both, not just a lack of knowledge but in fact an attempt by groups to exploit this rewriting of the Health Disciplines Act to limit the scope of practice of optometry. Certainly that is understandable, considering the sources. I am sure ophthalmology is concerned with the broadening scopes of practice in the United States. In my opinion again—I am just Joe Blow optometrist—they are using this process to knock us down a notch to prevent further evolution. That is personally what I think is the cause.

Mrs Cunningham: You have got it. Can I just say something that may or may not be reassuring? I think what you have to do is carefully monitor the input from the Ontario Medical Association next week. Make certain your group is there. I would suggest they may even make some kind of a positive statement on your behalf if they feel so inclined. If they do not, you will know where you stand and where the lobby is coming from.

From a practical point of view, as a person who represents people who want service, I personally agree with what you are saying today. I think you should be prepared very quickly to get the wording you want. If you do not have somebody who can draft it, get somebody who can draft it and get it to Mr Wessinger so he will know exactly where you are coming from. In fairness to the ministry, it will then know what your expectations are. That is my advice.

Dr Van Ymeren: Thank you, Dianne.

The Chair: Thank you very much. We appreciate your appearing before the committee today. I know you realize that if there is additional information you wish to share with the committee, that you feel might be helpful to us, you can do that in writing at any time during our deliberations through our clerk.

1440

LONDON REGIONAL PSYCHOLOGICAL ASSOCIATION

The Chair: I call the London Regional Psychological Association.

Dr Ferrari: Thank you for allowing us to appear before you today to present our concerns.

My name is Dr Jack Ferrari. I am the vice-president of the London Regional Psychological Association and a staff psychologist at London Psychiatric Hospital. My colleague is

Dr Bill Newby. He is the secretary of the association and the director of psychological services at St Joseph's Health Centre.

Before I begin our brief, I would like to mention that we are both involved in two other groups representing psychology. Dr Newby is a regional representative of the Ontario Chief Psychologists Association, and I am the president of the section on public service psychologists within the Ontario Psychological Association, both groups of which support the brief we are going to present today. In fact, our brief will essentially support the brief the OPA delivered yesterday.

The London Regional Psychological Association is a collegial association of over 80 practitioners, academics and students of psychology in London and the surrounding area. Most members are registered psychologists, doctoral graduates who are also registrants with the Ontario Board of Examiners in Psychology, the professional examining and licensing board since the passage of the Psychologists Registration Act of 1960, revised 1980. To be registered under existing legislation, individuals must have completed one year of post-doctoral training and have passed written and oral examinations covering general knowledge of psychology and principles of ethics and professional practice. Many of our members are also registrants with the Canadian register of health service providers in psychology. Such registration requires a minimum of two years of supervised practice or four years of post-doctoral experience in rendering health care services.

Our members occupy many different roles in health care and in other areas of professional practice in London and the surrounding areas. They provide direct clinical service to many kinds of hospital inpatients and outpatients, to clients of community agencies and through private practice. Our members' services include assessment and therapy for a variety of problems, including emotional disorders, chronic physical disorders such as pain, cancer and head injuries, substance abuse, infertility, sexual abuse, child custody and access as well as psychotic conditions. Many also perform administrative services in hospitals and are involved in community health care programs.

Psychologists are also involved in the training and education of other health care professionals in hospitals and schools in the London area, including those in such disciplines as medicine and nursing in addition to psychology. Members of our group are also active in areas outside what might be termed health care in even the broadest sense. We have members working within the educational system with the local school boards, acting as consultants to business and industry and within the criminal justice system, consulting for civil litigation and conducting client research not only within the health care system but within the community as a whole.

We fully support the introduction of the Regulated Health Professions Act, Bill 43, and the associated Psychology Act, Bill 63, with their goals of protection of the public and providing the public with freedom of choice of health care practitioners within a range of regulated professions. However, we wish to raise several areas of concern to the standing committee with Bill 63, the Psychology

Act, as it is currently framed, and with section 26 of the proposed Regulated Health Professions Act. The concerns with Bill 63 are in the areas of title protection and the domain of service to individuals. Our concern with Bill 43 lies in section 26, dealing with diagnosis as a controlled act.

Finally, we support the retention of the doctoral degree as the educational requirement for registration as a psychologist, but we also recognize the concerns of master's-level practitioners. We would support a solution such as associate membership in the college for these individuals.

Title protection: Under the existing Psychologists Registration Act, the title "psychologist" and also the terms "psychological" and "psychology" are controlled. In other words, individuals cannot make use of these words in describing themselves or a service offered without falling under the terms of the act and being obliged to meet its requirements for professional practice.

Under the proposed Regulated Health Professions Act and section 15 of the accompanying Psychology Act, only the term "psychologist" will be covered. Under this draft legislation, an individual who is not a psychologist could offer, for example, a "psychological service" or "practice in psychology" and operate quite legally without being subject to any legal restraints upon his practice or without being subject to any disciplinary body for any acts of malfeasance or malpractice. Such an individual would not be required to be under the supervision of an individual who was covered under the Psychology Act and could practise without accountability under the act. We see no way in which members of the public could be expected to make the distinction between a psychologist who would be registered and regulated and a psychological therapist or counsellor in psychology who would not be regulated.

To promote the protection of the public offered by the act, we urge that the terms "psychology" and "psychological" be controlled terms in addition to "psychologist" under section 15 of the proposed Psychology Act.

In a closely related matter, we are concerned about the restriction of the proposed Psychology Act, in section 15, to individuals "providing or offering to provide, in Ontario, health care to individuals." The proposed legislation does not define the term "health care," which leaves many of our members unsure as to whether some of their activities are covered by this act. For example, does a program dealing with assisting individuals to stop smoking come under the domain of health care? Does marital or family counselling or consultation on sexual dysfunctions come under the domain of health care?

If Bill 63 proceeds as proposed, we can see the only way of resolving these questions as being through expensive and time-consuming litigation after the fact. In addition, the practice of those members who provide services to industry, to educational systems, to the civil and criminal justice system and to private individuals whose problems may not fall under even the broadest definition of health care is not covered under the proposed legislation. This implies that such individuals could practise in the absence of any assurance to the public that their services are subject to minimal standards of practice or without legal recourse in the case of suspected abuse.

We can foresee a great deal of ensuing public confusion, in that many members of the public will undoubtedly find it extremely difficult to understand how some individuals can call themselves psychologists and be subject to a regulatory body and other individuals can also call themselves psychologists and have no such regulatory agency. It would seem to make much broader sense to ensure that all individuals wishing to call themselves psychologists or to provide a psychological service must be governed by a regulatory body, either through broadening the terms of the proposed legislation or through deleting the phrase "health care to individuals" from section 15 of the Psychology Act.

I will skip the rest of that section, as we are running a little short of time.

Our next concern is with diagnosis. Our members strongly support the provisions of the Regulated Health Professions Act, in subsection 26(2), to maintain diagnosis as a controlled act. Within hospital settings, the functions of assessment, diagnosis, treatment and consultation provide the primary areas of service for professional psychologists. We therefore favour the inclusion of diagnosis, as it is defined in subsection 26(2) of Bill 43, as a controlled act for psychology. Our members are strongly in favour of the principle of shared authority for controlled acts where those controlled acts are within the professional competence of the profession.

Our training includes an emphasis on the standardized objective assessment of individuals and groups that gives our discipline a unique perspective on individuals that is invaluable in assisting and providing a diagnosis. Psychologists have developed and use a wider variety of instruments to assist psychological diagnosis than do other professionals. We feel the provision of diagnosis is within the scope of professional practice in psychology. In supporting the retention of diagnosis as a controlled act for psychology, we do not mean to exclude other practitioners either from assessing for purposes of treatment or from regulated diagnosis within their scope of practice.

1450

Finally, on professional entry, under the current legislation entry into the profession of psychology requires a doctoral degree in psychology, as well as one year of post-doctoral supervision and the successful completion of written and oral examinations. Through the course of the health disciplines review, arguments have been made for an alternative route to registration. Our members are familiar with the general trend throughout North America to converge upon the doctoral degree as the criterion for entry into professional practice in psychology. We support the retention of the doctoral degree as a requirement for professional practice in psychology. At the same time, our members work on a daily basis with other professionals within psychology who do not have a doctoral degree and who provide high levels of professional service. There is substantial agreement that an associate membership would not be inappropriate and would provide professional recognition for individuals without a doctoral degree in psychology. Thus, many members do favour the establishment of associate standing under the Psychology Act which

would provide professional recognition and standing for individuals without a doctoral degree. Thank you.

Mrs Cunningham: I actually have a couple of questions here, if you can get them all on the record at once. First, I would like you to enlighten the committee with regard to the letter of agreement of the three associations. I am wondering if you in fact agree with the letter of agreement. I have a personal concern, given that I am aware this government is anxious to get this legislation through. My understanding is that your letter of agreement is for 18 months. So if you have to ask us questions, this is the appropriate time.

The second concern I have is about the title protection. I am asking you why you think the title protection was drafted the way it is in this current legislation, because it is very controversial within the London community. I would like your opinion on that.

The third point is that some of the groups that have come before the committee, just looking at some of the briefs, feel that only medical diagnosis should be a licensed act. Perhaps you would like to take this opportunity to respond to those groups that make that statement.

Dr Newby: Let me try to make a beginning, if I remember the questions as we go through. Our reaction to the letter of agreement, which we saw only this morning, has been quite positive. We are very pleased that we have this opportunity to strike some agreement with the presently unregulated health care professionals. It was not until you mentioned the 18-month time frame, though, that it caused me some concern, in that it was my assumption, in reading the letter of agreement, that it would not necessarily hold up legislation. I hope that is the case. Perhaps the question I do have for this committee is, what do we know about the time frame for putting this legislation through? Would the negotiations that the letter of agreement discusses in any way impede legislation?

Mr Wessinger: With respect to the matter of the time frame of the legislation, I really am not in a position to give you a determination on that, but with respect to the second point, I do not see your letter of agreement in any way impeding this legislation. We are very pleased we have this letter of agreement and we are pleased this action is being taken to try to resolve the matters.

Mrs Cunningham: There are another two issues.

The Chair: The other questions that were asked by Mrs Cunningham? You do not have to answer if you do not want to.

Dr Newby: I would be pleased to. Since these questions do concern the points we have raised, I would certainly be glad to do anything we can do to clarify them. I think the second question was, why was title protection legislation drafted as it was? It is a difficult question to answer from this perspective, but I infer that the rationale for the legislation being drafted as it was is that it is desirable to have some homogeneity of wording and regulation across the different professions. I certainly agree this is the case.

I think what we are arguing, though, is that in the case of the title protection legislation with respect to psychologists,

the one-size-fits-all approach does not work so well. We have articulated two reasons we believe that to be the case.

I chanced this morning on this document Better Protection and More Choice in Health Care, in which the question is posed, "How can I tell the difference between regulated professionals and other health care providers?" The answer with respect to psychology is: "Only a qualified psychologist can claim to be 'a psychologist.' Anyone who is not a member of a regulated profession and uses the title can be charged and fined" and so on. I am very supportive of that. It is what we would like and it is what would protect the public. I am not convinced that the way the legislation is drafted, that is what the legislation says. For example, someone working in a school board who falls outside the purview of providing health services to individuals presumably could call himself a psychologist without being regulated. So we support broadening the regulation to all those who can call themselves psychologists, thereby providing better protection for the public.

Similarly, I think the public would reasonably expect somebody providing psychological services, as we articulated in our presentation, also to be regulated. This is consistent with the findings of the Environics poll that OPA had commissioned. That poll tells us that the public expects somebody delivering psychological services to be regulated. I infer from it that the public then would wish it. That is an inference.

Mr Hope: My question is still around this area, because I have been reading this over and over and shaking my head sometimes. When I look at this part of the MA versus the PhD level, who has the more grass-roots, on-the-job training, I guess you could say, because things change day to day, is the MA more than the PhD level. Then I am looking at this. You are looking at this government to put it into legislation. You say there is a temporary, 18-month—I am saying, why can the MAs and the PhDs not get themselves together so that you are not forcing the MAs to—

Dr Newby: I sincerely hope we can get them together. I assume the letter of agreement is an article of faith to the effect that we can. I am not sure why you are saying an MA would have more training and experience when a PhD in fact has 10 years' worth of training.

Mr Hope: Well, 10 years of the schooling, academic level of it versus on-the-job and being on the front. I am not a professional of the field, but I am saying, who is the one who is dealing with the public on a day-to-day structural basis? In my own mind, I think the person who is dealing with the public day to day would have that.

Dr Ferrari: Excuse me, but I really want to respond to that. A PhD has an MA. You get an MA and then you get a PhD, so I do not understand how an MA would have more training in any sense. An MA who goes out to work with his MA will get on-the-job training; so will a PhD. I have a PhD. I work with the London Psychiatric Hospital. I have been working there for almost six years. Before that, I worked at St Thomas Psychiatric Hospital for 11 years, front line, on the job. Many of my colleagues are in the same position. It has nothing to do with the degree.

Somebody with a BA can go and work in a hospital and get front-line training.

The Chair: I have a question from Mr Beer.

Mr Beer: My question has been answered, thank you.

Mr J. Wilson: I really have a question for the parliamentary assistant. If a person is accepted as a member of the college, does he not fall under the full effect of the act, no matter what setting he is in, whether educational or institutional? Maybe that would clear up this thing. This keeps appearing in briefs.

Mr Wessenger: Maybe I better refer that to ministry staff.

Mrs Cunningham: Oh, come on, Paul, you could have done that one.

Mr Burrows: As a member of a professional college, you are responsible if you are practising the profession. It is not site-specific; you practise the profession, period.

Mr J. Wilson: I did not understand that. If you are accepted as a member of the College of Psychologists of Ontario, you are deemed to be a psychologist under this act?

Mr Burrows: Yes.

Mr J. Wilson: You have title protection. Just trying to get some understanding of the "delivery of health services," that phrase, would not a psychologist be a psychologist be a psychologist, whether in an educational or other institutional setting?

Mr Burrows: I certainly do not purport to be an expert on psychology, but it is our understanding that there is a small percentage—I believe we have correspondence something to the effect that 8% practise in settings other than health care settings; for example, providing advice as an industrial psychologist about the colour of walls and the effect that will have on people's attitude at work sort of thing. So there are certain activities, according to the information that we have been provided, where it would be pretty farfetched to consider that they really are in the sphere of health care.

1500

Mr J. Wilson: Just along this line, the answer from the ministry to the witnesses who have raised this point before has always been they are not really, as you have just said, delivering a health care service, so they do not fall under this act. But maybe the corollary would be, does that mean they are allowed to join the College of Psychologists of Ontario?

Mr Burrows: It is possible to be a member of a college and not practise actively in the area. For example, I am a member of the Ontario College of Pharmacists, but I do not actively practise pharmacy.

The Chair: But if you did.

Mr Burrows: But if I did, then I would be accountable to the college for my performance and behaviour.

Dr Newby: And further, would not be required to register with the college. I am sorry I am speaking out of turn.

Mrs Cunningham: But just in clarification, the majority of psychologists are not in the health care professions, I would guess, at all. I am not arguing because you

are guessing and I am guessing, but my view is that the majority of psychologists are not in health care. I mean, has anybody ever added it up? You are the professionals—

Dr Ferrari: Yes, they have, and they come up with that 8% figure by defining health care or related areas in a certain way.

Mrs Cunningham: Well, that is the issue, is it not?

Dr Ferrari: If you define it more narrowly, then probably the minority of psychologists are in health care.

Dr Newby: It is hard to do in the absence of that definition.

Mrs Cunningham: Exactly.

Mr J. Wilson: But in this act, though, you are saying the problem would be solved if everyone was required to register with the college in no matter what setting they are delivering psychological services?

Dr Ferrari: Yes, that is the way it is right now, in fact.

Dr Newby: That would not bring them under the regulatory umbrella, because the regulatory umbrella, as I understand it, refers to those who are engaged in the delivery of health care. So the problem of protecting the public I do not think would be solved except internally within psychology.

The Chair: Thank you very much for your presentation. We appreciate you coming before the committee today.

Just to clarify, and if I am incorrect I know that the ministry officials will correct this, it is my understanding as a statement of fact that anyone who qualifies with any college's role regarding entry to practice can apply to the college to join and be a member of the college, and it is then up to the college to determine whether or not that individual meets the entry requirements as that professional.

Mr J. Wilson: No, I understand that, but when they are appealed, what act do you fall under? If you are delivering—

The Chair: This legislation covers an individual, it is my understanding, who is delivering a health service, health care, and it is not site-specific. That is how I understand the interpretation, and Hansard will note that the two people on my left have said that is correct.

Mr J. Wilson: Well, I understand that, but the committee is grappling with those in other settings, given the lack of definition of health care.

The Chair: Okay, but we may want some time to discuss this further, and you will have that opportunity at least on the 16th and 17th of September if not before then.

ONTARIO ASSOCIATION OF SOCIAL WORK ADMINISTRATORS IN HEALTH FACILITIES

The Chair: I would like to call now the Ontario Association of Social Work Administrators in Health Facilities. Please come forward, introduce yourselves to the committee. You have 20 minutes for your presentation, and if you leave a few minutes for questions we would appreciate it. Please begin now.

Mr Pretti: First of all, thank you very much for the opportunity to meet with you and to present our views. My name is John Pretti. I am manager of social work at University Hospital. With me is my colleague Anne Sawarna,

who is director of social work at the London Regional Cancer Clinic.

We are speaking on behalf of the Ontario Association of Social Work Administrators in Health Facilities, and we represent more than 1,000 front-line clinical social workers in hospitals. In addition, there are approximately another 1,000 social workers employed in a variety of mental health and other programs that are related to hospitals or that are based in the community. So as managers we are directly both administratively and clinically responsible for those social workers.

Let me talk a little bit about what we do as social workers. I will restrict my comments to social workers in health care. Similar to psychology, you probably know social workers are involved in many other settings, education, addictions field, corrections, etc, but I will restrict my comments to the health care field.

It is estimated that approximately 40% of patients in acute care hospitals have psychosocial problems which may affect their recovery, their utilization of health care or their return to the community. Social workers are front-line health care providers who deal with and respond to the emotional, the mental, marital, family difficulties that are related to health care, to illness, to recovery. In that sense, we as social workers deal with a variety of personal and family difficulties that are often exacerbated by illness, by hospitalization, and often these individuals are most vulnerable in society.

Overall, we as an association strongly support and are supportive of the proposed legislation, particularly since it addressed such important issues as protection of the public, recognition of consumer choice and it provides a common mechanism for regulation of the health care professions. There are, however, three areas which I want to discuss where we have major concerns which we hope this committee will address.

First of all, and many of you know this already, social work is absent from this legislation. In my view, it should have been included under this legislation, but it is not for a number of reasons. We now have a circumstance in Ontario; this is the only province that has no governing body for professional social work, and when this legislation passes, social work will be the only unregulated profession in the health care field. We have well over 2,500 university-trained professional social workers working not only in hospitals but in a variety of addiction centres, community-based family practice units, mental health clinics, psychiatric hospitals, etc.

We, the social workers in the province, have taken the initiative. We have a voluntary college. There are two things I think this committee can do. One, it can make a recommendation to urge this government to provide some form of regulation for the practice of social work in the province, either within or outside of this act.

The second area I want to discuss, and that is the area I want to focus on primarily, is our concern with the diagnosis clause or section 26. We urge you to consider this very, very closely. If you will look at page 5 for a moment—I know time is limited—let me give the illustration at the bottom of page 5 of a scenario that might involve a 67-

year-old man with liver cancer referred by the oncologist to the social worker for an assessment.

The patient's daughter stated to the physician that her father was having difficulties coping with his illness and appeared to be depressed. Upon receiving the referral, the social worker saw the patient and was able to observe the neurovegetative symptoms of depression and the fact that the patient was quite withdrawn.

As part of the assessment and diagnosis, the social worker interviewed the patient's 40-year-old daughter who also confirmed marked confusion on the part of her father, a marked confusion that is not normally related to straightforward depression. The daughter confirmed that her father had attempted to put on his coat but mistakenly had chosen his wife's coat and could not determine the problem with the fit. A daily churchgoer, the patient could not remember the directions to the church, which also substantiated significant cognitive deficits.

Now, in this example the social worker was able to assess or diagnose that this depression, this withdrawal, was not related to normal grief or reaction depression but related to organic factors. Again, you could see how difficult it would be or how impossible for us to practise in our daily routine if we were not able to discuss the implications and the meanings of this "illness" with the patient, or in this case, the patient's daughter, as well as the oncologist.

1510

Social workers, like others, work in health care teams and have responsibility for communicating the diagnosis and the implications. Of course, the diagnosis forms the basis of a therapy or treatment plan. I urge the committee to either remove this section from the act or provide provisions which would clearly exempt social work from the possibility of being subject to—in fact, the social worker would be at risk of being prosecuted for carrying out what we see as normal practice in our day-to-day work.

I move on quickly to the last section. The last point I want to make is the harm clause. Generally speaking, we support the fact that this committee has dropped it; we hope you will not reintroduce it in some form. It lacked quality. We, as an association, have in fact expanded our comments in this area.

One last point which is not in the brief: Section 30 does restrict the use of the title "doctor" to five professional groups. I have several colleagues in clinical social work who have PhDs from universities in Ontario, like Wilfrid Laurier University, the University of Toronto in clinical social work. I think recognizing the PhDs of others and not of social workers practising in health care, would really result in an atmosphere of inequity. I hope this committee would reconsider this exclusion and allow social workers who have a doctoral degree to use this title.

Just in summary, we would ask that you consider, first incorporating social workers in this act and, if that is not possible, to make a strong recommendation that this government act to provide us with separate regulation—in fact, the previous government had committed itself to enacting social work regulation;

Second, modifying the diagnosis clause so as not to restrict the services of hospital patients and other health

care clients. Again, I want to emphasize how important that is in this community and I am sure in other parts of the province. People need mental health services, marital and family therapy, and to further restrict—I think that would be the effect. Maintaining this clause the way it is written would certainly not do justice to these vulnerable people in society.

Third, we would ask that you not reconsider the harm clause.

Mr Owens: Each time an unregulated practitioner brings the question of the diagnosis clause forward, I find myself struggling and trying to determine exactly why you folks find it problematic. I am wondering if it is around the usage of the word "dysfunction," which tends to be more within the realm of a condition—I am even trying to pick my words carefully—that you would identify rather than a disease or a disorder.

In your example of working on the oncology floor, do you actually feel that you are diagnosing or communicating that diagnosis to the patient rather than perhaps in a supportive role of the oncologist?

Mr Pretti: I can answer that. Yes, I do feel we are diagnosing. Perhaps a better example is in the mental health fields. For example, if I see a couple referred for therapy, perhaps initially the wife appeared in the mental health clinic with mild to moderate depression. When I or my staff see the couple for assessment, certainly in a mental health context that relationship in many respects is very dysfunctional. Yes, a diagnosis is used.

In fact, we use, as probably many of you know, the criteria in the DSM III in the mental health field and use them to diagnose and to communicate, in this case to the couple, our observations. As well, in the pursuing of therapy, we would hopefully engage the couple in correcting or altering various dysfunctional aspects in their relationship.

Mrs Cunningham: I will hit another area. I am wondering, perhaps for clarification not only for yourselves but for the committee as well, if someone here can enlighten us as to the first request here in the summary, and that is either a social work act which we thought was almost ready or the inclusion here under this bill. Madam Chair, I do not know who you want to refer that to, but I certainly think we should hear it now.

Mr Wessenger: I do not think really I can answer that question with respect to the social workers' act because it is really not within the framework of our ministry, but maybe ministry staff could clarify further.

Mr Burrows: The Ministry of Community and Social Services remains the lead on the issue of the regulation of social workers. You may recall that in the early years of the review there was a decision that social workers more appropriately would be regulated under that area. There was some form of agreement that this would be the chosen path. Since that time I understand that the groups who speak on behalf of the social work profession at the provincial level have been working with that ministry.

As far as I know, those discussions are still ongoing. We have heard some evidence at committee along those lines to indicate that the discussion is occurring. I believe the Ontario Association of Professional Social Workers is

on record in Hansard with respect to its position on the matter, which I think is consistent with that approach continuing. I think it is fair to say that we have also heard that the options you have put forward have been expressed by other social work representatives as well.

But for now, our ministry, Health, does not have government policy approval to be the lead on this issue. We would not see social work being under this particular umbrella, at least at this time.

Mr Pretti: I hope you realize that we are left in jeopardy in the meantime if this act passes and we are left literally unprotected in terms of providing health services.

Mrs Cunningham: Mr Pretti, it is my understanding that the Ministry of Community and Social Services representatives will come before this committee before final deliberations are made. It is my understanding that this request has been put to the ministry. If we do not think there is movement, because some of us have been waiting for a very long time, then perhaps the committee will proceed to make some amendments to this legislation as it sits. Certainly that is the intention we have in our caucus.

1520

LONDON BIRTH CENTRE COMMITTEE

Ms Johnson: Good afternoon. My name is Edythe Johnson, and I have with me Erica Brophy and Linda Hearn from the London Birth Centre Committee. Brad Keeler on your list was to be with us and got called out. He has asked me to read his presentation. I will do that for him and I will attempt to entertain questions upon his presentation to the best of my limited ability.

The London Birth Centre is a group that consists of a strong, consumer-driven core and a very broadly based, interrelated professional board of advisers, working together to bring a birth centre, freestanding, to London, we hope in the near future.

First I will begin by reading Brad's presentation. Brad Keeler is one of our advisers and he is involved in health care consultant work. He would like to address four major points: acceptability and accountability, continuity, quality and cost. They must all work together if the new disciplines are to work to the benefit of the patients and the taxpayer. If the patient has no choice of provider, that is, only a physician and only a hospital, then her accountability for following advice in the final outcome is reduced. Allowing the patient to choose from among providers has the potential to increase patient responsibility, a major benefit to the system.

I am concerned about self-discipline versus public accountability. Please ensure strong consumer, male and female, representation on committees. Perhaps the public should own the professions. This could be reinforced by 51% consumer membership. Perhaps it could be moderated if a two-thirds vote was required to adopt motions for both the colleges and the complaints and disciplines committee.

Consumers should have a stronger voice if they are to be respected and empowered and their wishes to be reflected. Why not link complaints and disciplines together? It seems like a duplication of effort, creates the potential for mistakes and lengthens the adjudication process. The jury who hears the case should determine the penalty. Ensure that

the link between physician, midwife, birthing centre and hospital is transparent to the patient. Increased complexity should not increase confusion for the patient. The temporary or permanent transfer of care from one provider institution to another must be easy. Interprovider links should be formalized in the legislation. It should not take more than a decade to shift responsibilities between professions in the future as technology changes, which the current legislation has taken.

Allow midwives to perform tasks based on technical competence and ability, rather than based on the desire of another profession to restrict service providers. An example is intravenous reinsertion for rehydration.

I am concerned about grandmothering. The standards being developed for midwives seem to be a model for other new disciplines and for foreign graduates wishing to practise in Ontario. There is no comment about setting educational programs. Although it is not specifically part of the act, it is very important. It is essential to ensure quality of care.

In terms of cost, support midwives as primary care givers. Enable them to function parallel to existing systems. Cheap teaching hospitals receive an average of \$1,750 per normal birth, excluding the cost of the obstetrician-gynecologist and general practitioner. In the US midwives are funded as individual providers, along with doctors, at a percentage of the fee paid to the physician. I do not support piecework fees, but ensuring that we get value for our dollar is important. To control costs, attach midwives to birthing centres or to hospitals prior to funding support.

This is respectfully submitted by Brad Keeler.

Ms Brophy: My name is Erica Brophy and I am a member of the London Birth Centre Committee. I support this legislation and the legislation that would fully recognize and register midwives in Ontario.

I used the support of a midwife for my labour and the birth of my daughter in June of 1990. I also drove an hour and a half from Dresden to London to partake of this service. The support I received from my midwife made it possible for me to remain at my parents' home in London during my labour for all but the last hour before my daughter's birth. This was important to me because when we were in my parents' home my husband and I felt we had more control over what happened during the labour and we could more easily avoid unwanted interventions. I also feel that I was more relaxed in the home setting than I would have been in the hospital and therefore my labour progressed more easily and perhaps quicker than if I was tense and uncomfortable.

I was very pleased with my labour and delivery except for two things. The first was that moving from my parents' home to the hospital in the very late stages of labour was not the most comfortable experience, and it would have been unnecessary if a birth centre had been available. The second drawback to having my daughter in hospital was that she was taken away from my husband and myself to go to the nursery. We would have preferred to have her stay with us the whole time, and this will be the policy of the London Birth Centre.

My husband and I did not feel comfortable having a home birth for our first child in case something were to go wrong. Unfortunately, there presently is nothing in between hospital births and home births. A birthing centre would fill this gap. My husband and I have discussed the options and we have decided that when we have our second child we want the right to the birth of our choice, and that would be in a birthing centre.

Accessibility to midwife care should be available to all women regardless of their risk category. The support and continuity of care a midwife can offer, which a physician often does not have the time for, is especially important to a woman undergoing a high-risk pregnancy and delivery. Having someone the woman has developed a relationship with over a number of months present at a high-risk birth can help reduce the mother's stress and can make her feel better about all the different procedures that are performed on her. Some mothers would even like to have their midwives present during the Caesarean sections, if they are given a general anaesthetic, so that she can describe what occurred during the birth to the mother later and also so that she can be there for their child and make sure that baby gets to meet dad and the rest of the family as soon as possible.

Sometimes a very normal pregnancy develops indications of a possible problem during labour. Midwives will immediately transport the mother to a hospital to have the backup equipment and expertise in case a problem does develop. Often no problem does develop and a normal birth ensues.

Midwives should be able to remain as the mother's primary care giver during the transport to the hospital and at the hospital until it becomes apparent that there is a real problem and the expertise of another professional is needed. Even at this time the midwife should be allowed to remain with the mother in a supportive role. When a birth starts to go wrong the mother still requires as much, or more, support. Having her midwife with her will continue to give the mother the emotional support she needs and will help her to feel more positive about the lack of the normal delivery she had hoped for. This continuity of care can also help the mother and her child after they return home from the hospital. Mothers who have had a difficult birth may be very nervous about the wellbeing of their child, but having someone they have developed a relationship with, who was also present at their child's birth, to ask questions of would help to alleviate their fears. I strongly recommend that this committee ensure that the legislation facilitates continuity of care.

Midwives have an important role to fulfil in our society. However, at present there are far too few of them and they are really only accessible to the fairly well-off. If this act and the Midwifery Act are both passed, midwives will become available to anyone who wants one and midwifery will become a more enticing profession for others to train for. Birthing centres will also become the perfect training centres for new midwives and a perfect middle ground for women who want to have a non-hospital birth with a midwife but are nervous about having a home birth.

We support and applaud this government's innovative approach to health care through this legislation. We also ask

you to be attentive to the ways in which this legislation can continue to enable professional autonomy for midwifery.

The Chair: Thank you for an excellent presentation. Are you finished?

Ms Johnson: No, there is one more piece, and I will be presenting that. As I said, I am Edythe Johnson and I am the past president of the Association of Ontario Midwives and currently the Canadian co-ordinator of the Canadian Confederation of Midwives, but today I am speaking on behalf of the London Birth Centre.

This legislation leads us to a more open, consumer-responsive and publicly accountable health care system through open public hearings, increased public membership on councils, greater public input to policy decisions through the Health Professions Regulatory Advisory Council, and recognizing new disciplines, thereby increasing choice for the consumer and enhancing the opportunity for alternative approaches to effective health care. It has my full support.

The comments I wish to make are specific to Bill 56. To ensure that the proposed scope of practice for midwives as primary care givers is enabled and to ensure continuity of care can be provided by midwives, I support the draft amendments submitted by the Minister of Health to this committee, those being the ability to perform heel pricks, insertion of urinary catheters and the ability to prescribe certain drugs as specified in legislation; and those requested by the Association of Ontario Midwives, those being the ability to do prenatal blood screening, insertion of intravenous catheter for the purpose of rehydration and dispensing specific medications in specific post-partum situations.

The introduction of the profession of midwifery into the health care system will provide childbearing women with the physiologic model of care that is quite different from the existing medical model. It is important to give thought to how best to maximize the full benefits midwifery has to offer our public.

Autonomous, freestanding, community-based birth centres will provide a home base for midwifery practice that facilitates the focus on birth as normal. The level ground a freestanding birth centre provides will allow for the greatest opportunity for balanced interprofessional relationships and cross-education of other professionals, impacting other disciplines and settings through the experience of a healthy comparative to what currently exists within the system.

Many consumers of midwifery care have, for some time, expressed a desire for an alternative location to give birth. Currently women have only the choice of hospital or home in which to give birth. A freestanding birth centre provides the community-based and community-responsive environment for a large number of women who need a middle-road option in regard to the place of birth.

The integration of midwives and the implementation of freestanding birth centres together, simultaneously, is essential to best maintain and continue to develop optimality within the profession of midwifery, so that the full spectrum of benefits of midwifery care will be enjoyed by consumers, our communities and our health care system. Thank you.

1530

Ms Haeck: I would like to address some of Mr Keeler's concerns. It relates to a presentation we had earlier. Ms Johnson, I believe you were present in the audience. With Mr Keeler not being here, I understand that possibly you could carry this back to him.

Ms Johnson: I will do that.

Ms Haeck: In relation to when the colleges are set up, it is my understanding that the colleges will be determining who qualifies to practise within the province, so that they will be looking at whether or not, as one of the earlier presenters outlined, there will be foreign qualified midwives accepted. It definitely will be something I would assume the College of Midwifery will be looking at, and they will be preparing the regulations for those qualifications.

To further address one point under "acceptability and accountability," it has been a proposal for this piece of legislation that the consumers make up just under 50% of public representation on the quality assurance committees. I guess my question is why Mr Keeler would like to see it at 51% as opposed to, say, 45% or 48%, whether there really is that much of a difference, in light of the fact that other midwives or people who have been supportive of midwifery have felt that people on the committee should have a good understanding of midwifery before they are appointed to those positions.

Ms Johnson: Are you asking me to address that or to take that back to Mr Keeler?

Ms Haeck: Just take that back to him, if you would.

The Chair: And inform him as well that he can communicate with our committee in writing in response to Ms Haeck's questions, if you would, please.

Mrs Cunningham: I am just wondering whether you have discussed the qualifications. It certainly seems to be something that has been raised as a concern before our committee. I am wondering whether you have had any internal discussions, or just what your ideas on that issue would be.

Ms Johnson: In terms of the London Birth Centre and qualifications of midwifery?

Mrs Cunningham: No, of midwives.

Ms Johnson: In the association. The London Birth Centre is in agreement, thus far, with the Association of Ontario Midwives and the Interim Regulatory Council on Midwifery. As part of their process, the interim council is looking at standards and scope of practice and regulatory tools that will ensure a high level of training and ongoing competence for midwives.

As part of the government's impetus to bring about midwifery in the province, it appointed a midwifery implementation planning project recently, which has made recommendations to the minister that will ensure current practitioners are integrated into the health care system in such a way that we have a baseline of competence that is acceptable to the public and other professionals as well as midwifery.

I believe it was Mrs Caplan who referred to it earlier. This pre-registration program will have baseline eligibility

criteria that have been developed before admittance, and then probably at least six months to one or two years of process to bring everyone up to a level all of us can feel competent and confident with. At that point registration and licensing will be provided, but not a degree. In terms of overall qualification for midwifery, a four-year bachelor of science in midwifery has been recommended thus far, and supported by both our association and by the London Birth Centre Committee members as the route to go.

Mr Beer: I am interested in the point you make at the end of your submission about the integration of midwives and the freestanding birth centres, and that was also reflected in the submission by Mr Keeler. Could you expand a bit on that? Are you saying that midwives could practise independently, but as part of setting up a birth centre you would want to have midwives permanently assigned to those? What do you mean by "integration"?

Ms Johnson: Sites of practice are still under discussion for midwives, but we do see that the maximum benefit of midwifery care would be enjoyed by allowing various settings for practice. As I said, currently you can have a home birth, which is not entirely isolated but more isolated than a supported environment, and therefore only certain people would be considered a safe risk for that, and only certain people would choose that; you can have a hospital birth that is governed by the medical model and other professions; and more and more it is seen that this middle-road option of a birth centre, that is based on the care delivery it would provide, based on the physiological, normal perspective of birth and staffed by midwives, and also available to family doctors who choose to work with it and are philosophically in agreement, would give a home ground.

Mr Beer: But the main point is that midwives would be the primary health care providers there?

Ms Johnson: I think that would depend on the community. These are community-based, community-governed, consumer-driven and -directed.

Mr Winninger: There has been a concern expressed regarding the role of the midwife as primary care giver in a hospital setting vis-à-vis, say, the lead nurse in the delivery room, a question of whether authority would be shared or who would be subservient to whom. I wonder whether you could comment on that.

Ms Johnson: I can comment on it as one midwife who has worked in the hospital setting over several years, and also in terms of reflecting for my association that we are most interested in working co-operatively with nurses. Midwifery needs to be primary care as a functional profession in order to deliver continuity of care and to deliver as much as midwifery can to its clients and to women. To restrict the ability of midwives to care for their clients would not be wise. At the same time, we do not support a hierarchical system of care delivery, and so we are most interested in working co-operatively with nurses and do not see that there would be a reduction in the importance of a nurse's role overall.

1540

MIDWIFERY TASK FORCE OF ONTARIO, LONDON CHAPTER

The Chair: I call next the Midwifery Task Force of Ontario, London chapter.

Ms Haffie: Thank you. The Midwifery Task Force of Ontario is a not-for-profit, consumer-based organization that has been working toward the recognition and legalization of midwifery since 1983. Much of our work has been launched from the kitchen table or over telephones with extended cords that allow us to kiss spouses, wipe noses and prepare dinners while educating, lobbying and fund-raising from Thunder Bay to Cornwall to Windsor.

The MTFL—and I will not throw any more acronyms at you, that is the only one—is one of 17 chapter groups across the province. I am Sue Haffie. I am the local co-ordinator of MTFL and the president-elect of the Midwifery Task Force of Ontario. With me is Michele Girash Bevan. Michele is a member of the local chapter and the regional representative for southwestern Ontario. We are delighted to be here and welcome the opportunity to speak to you on behalf of the women and their families from the London area, who make up our chapter.

London's only practising member of the Association of Ontario Midwives served our community for over seven years. She offered a unique quality of service to birthing families. Unfortunately, she is currently on medical leave and we are now faced with travelling to access midwifery care.

We look forward to legislation to improve access to the benefits of midwifery care in our community and all communities in Ontario. We offer our support of the overall intent of the Regulated Health Professions Act and, in particular, the Midwifery Act. Bill 56 establishes midwifery as an autonomous profession, provides more choices in care givers, makes midwifery a financially feasible option and allows for community-based health care which will lead to more preventive health care versus crisis intervention.

Ontario midwifery has come to be because women have insisted on an alternative to the care being offered to them that would recognize the importance of three main principles of midwifery care. One is continuity of care. This involves regular 30- to 60-minute pre- and post-natal visits with one or two primary care givers with whom the birthing family has developed a long-term relationship. It is knowing that a knowledgeable, trusted care giver will be there to offer safe and effective care. Second is informed choice. Midwives recognize women as decision-makers. They offer education and support to empower women to make responsible, informed decisions about their own health care. Third is choice of birthplace. Midwives and their clients recognize that home, freestanding birth centres, hospital-affiliated birth centres and hospitals may all be safe and appropriate places to give birth.

Ms Bevan: I would like to focus on one of those criteria, and that is continuity of care. Again, to us continuity of care means maintaining a health care relationship with a carefully chosen care giver throughout the pregnant year; in essence, finding a face you trust and seeing that face at every prenatal visit, through labour and birth and at post-natal visits.

Midwifery care provides continuity of care. It recognizes that continuity is necessary for a healthy, safe birth.

The Midwifery Act, as written, defines the scope of practice as "the assessment and monitoring of women during pregnancy, labour and the post partum period and of their newborn babies, the provision of care during normal pregnancy, labour and post partum period and the conducting of spontaneous normal vaginal deliveries." We are concerned about the use of the word "normal" here. What is normal and who is to decide what normal is?

Historically, midwives and medical practitioners have differed on their definition of "normal." Midwives believe that birth is a normal physiological process. Midwifery philosophy maximizes normalcy and dissuades intervention. On the other hand, some obstetricians may view the birth canal as a dangerous place for the baby-to-be. There is a quote of physicians saying, "Birth is only normal in retrospect." Obviously these two views are not in agreement. In order for midwives to be an autonomous body, we feel it is necessary to have an independent definition of "normal," otherwise women may be caught in the middle of a dispute between midwifery and medicine.

There are a couple of examples that might help to illustrate my point. On a personal level, I have had one previous caesarean section. According to the Association of Ontario Midwives' guidelines to the scope of practice, if I have a healthy pregnancy with my next child I will be considered normal. According to many medical practitioners, however, I am a high risk and would not be considered a candidate for midwifery care. The two views do not agree.

As another example, one of our members experienced high blood pressure in her first pregnancy and labour. She was induced at 38 weeks. Induction of labour may have a place in some cases, but in many instances it is associated with an increased risk of further intervention, of forceps delivery, of C-section, etc. In her second pregnancy Beth acquired midwifery care. Again she had high blood pressure. According to some medical practitioners, she could have then been considered high risk and not a candidate for midwifery care. Her midwife prescribed a special diet, her blood pressure came down and she had a healthy home birth. Again in this situation, where midwifery philosophy maximizes normalcy, medical philosophy would emphasize illness. We need to be assured that women in this kind of situation will still have access to midwifery care.

The Interim Regulatory Council on Midwifery has spent a great deal of time developing mandatory guidelines for consultation and transfer of care. We have appended our submission on to this document for your consideration, and we hope that "normal," as used in Bill 56, will be in keeping with the recommendations in this document.

Also as written, Bill 56 describes the scope of practice for midwives, as I said, in regard to normal pregnancy and birth. We would like to ask this committee if this means that those women who are assessed as being high risk, where there is no question that they are high risk for whatever reason and therefore are under the primary care of a physician, will still be able to access midwifery care in a supportive role.

When we choose care givers, we tend to pick them on the basis of competence, common philosophy and personal compatibility. To put it simply, when I choose a midwife I will choose her because I trust her and I feel safe with her as my care giver. Pregnancy is a time of great emotional upheaval. There is lots of excitement, lots of anticipation, but there is also anxiety. If I find a care giver who can make me feel safe, that can reduce much of that anxiety and lead to a better and healthier pregnancy and birth.

If, however, I fall into a high-risk category, I still need that trust and safety and continuity even more. If I have those birth plans destroyed, if I have to deal with strangers I do not know and do not necessarily trust, then anxiety takes over, and anxiety can be disastrous in pregnancy and birth. If I can retain the services of my midwife for emotional and psychosocial support, to keep my birth as normal as possible in that high-risk situation, to prevent that cycle of intervention that is all too common in high-risk pregnancies, then much trauma can be avoided. In such a case, the midwife can be a counsellor, an advocate of normalcy and a knowledgeable source of information. She can still provide that familiar face, that continuity of care, throughout the birth and the post-partum period.

Ms Haffie: Consider the women who has a caesarean under general anaesthetic. Her partner is not permitted to be with her. Part of their birth experience is blocked out. That part is missing. Midwives who have been permitted into the OR play an important role in filling in that gap. They can relate all of the details of that missing part and connect the lost moment. Women never tire of hearing about or telling their birth stories, whether it is five, 25 or 105 times.

Ms Bevan: We are also concerned about the single mothers, those of them who are young and scared. Most of the single mothers that you hear about are younger and alone. Having a normal birth alone, without a partner, is frightening enough. To be in a high-risk situation in that cycle of intervention, with machines and IVs, would be absolutely terrifying. If that woman can access midwifery care in a supportive role, with her physician as a primary care giver, then she can still have that familiar, trusted face to provide continuity and to make the birth experience and that entry into parenthood as positive as possible.

Ms Haffie: My first son was born by caesarean section. The diagnosis was "failure to progress." My family physician was discussing her living-room drapes as the obstetrician was slicing me open, discussing home renovations when I felt the anaesthetic was freeing my lungs and I really felt like I was going to die.

Before the conception of our second son, my husband and I decided we would hire a midwife. We wanted to build a trusting relationship with one of those guardians of the normal birth so that if my second pregnancy had ended in a caesarean section, we would have been assured of its necessity. And a midwife at the same time would have made sure that caesarean birth was a birth experience and not an operation happening to me.

1550

Ms Bevan: When I had my son—we are talking about birth experiences here—I had a wonderful pregnancy. I loved being pregnant. But the labour was another story. I was put to bed. I was not allowed to eat. I was anaesthetized, monitored, and I had a C-section too. I saw lots of faces, but did not know very many of them. I had looked high and low for a doctor I trusted and whom I felt comfortable with and I saw her for a maximum of four hours out of 38 at the most.

I was not told that when I had epidural anaesthesia I would have these horrible, tremendous shivers. I was not told that epidurals slow contractions and thus labour and lead to more complication. Although I can never prove it, I feel in my heart that many of these interventions were unnecessary. By providing continuity of care and informed choice, I feel that a midwife could have empowered me to avoid these interventions. If I had had access to midwifery care, maybe some of this could have been prevented.

Thus, we would like to ask the following questions about the act:

Given that the midwifery scope of practice as defined in the act refers to normalcy, a scope of practice under normal conditions, will women who are assessed as high risks still be able to access midwives in a supportive role? Will this be legal? Will it be paid for? And will the decision to retain the services of a midwife, after transfer of care to a physician has occurred, remain with the client? Will that woman still be able to say, "I want my midwife with me even though I am seeing a physician"?

Ms Haffie: We would also like to ask the standing committee for clarification regarding consumer representation on the governing council of the College of Midwives of Ontario. On April 2 of this year, Minister of Health Evelyn Gigantes announced that public representation on the governing councils of health professions would be increased from one quarter or less to just under half, and we have appended that to the presentation as well. Bill 56, however, as far as I can figure out, provides for a maximum consumer representation of only 38%, and I wonder if maybe you could address that in the question period.

Ms Bevan: In summary, we are pleased to support Bills 43 and 56. We feel that the Regulated Health Professions Act will empower the health care consumer, will put the consumer back in the decision-making position. Similarly, the Midwifery Act will allow all women who wish to access midwifery care to do so, regardless of their financial status. It will put the woman back at the centre of childbirth, instead of the health care provider.

We feel the implementation of legislated midwifery in Ontario will allow better consumer involvement in health care, will result in healthier births and will save money on health care and hospital services. We proudly support Bill 56 but we reiterate our concerns that the definition of normal pregnancy and labour may cause some problems and that it is necessary for all women, regardless of risk assessment, to be able to access midwifery care.

Ms Haffie: Midwifery consumers are proud and excited to be so close to realizing our dream. We have been

working hard for over eight years towards the recognition and legalization of midwifery. It is very close and we are very excited. This legislation did not just happen; you listened to us. And we thank you for listening to us today.

The Chair: Thank you very much for a very thoughtful and excellent presentation. I will ask the parliamentary assistant to respond first.

Mr Wessinger: If I might respond to the whole question of the governing council, an amendment will be tendered at the clause-by-clause stage of the discussion of the bill. Right now, I understand the whole question of numbers is a matter of discussion with your council. Once that is agreed to, I assume that it in fact would be the figure that is agreed to and that will be put in the bill. So it is being worked out, as I understand.

Ms Haffie: I am sorry. This is the interim regulatory council which will be working out the numbers?

Mr Burrows: The numbers for all of the governing bodies, in light of that policy statement of the minister, are being discussed with whoever the authority is. In the case of an existing profession, it is the existing governing body. In the case of those to be regulated, it is the group which is seen as being the voice of the profession. That consultation is going on. We have received input. It has been digested. In some cases there is acceptance, in some cases there is a request for clarification, and so forth.

When that process is complete we will be recommending to the minister specific composition numbers and, if approved, they would form the basis of amendments at clause-by-clause.

The Chair: There were other questions that were asked regarding midwives in complementary care, as well as whether this would be covered. Do you want to answer that at this time?

Mr Wessinger: I will comment on it. First of all, with respect to "in a supportive role," that of course naturally would be allowed with the physician's agreement. So that would be legal in those circumstances, but it would have to be worked out with the individual physician.

With respect to the other matters, they have not yet been resolved.

Mr Martin: I rather enjoyed your introduction as you spoke about sitting around the kitchen table and discussing this. You are in rather an enviable position, I think, as a group, talking among yourselves about how this particular service might be delivered and then coming up with some of the rules around, I suppose, what credentials midwives may have. It is certainly an issue that has been raised at this level, and my question would be around that.

It seems to me that probably most of the health professions started somewhere back in history at that same place, where consumers who had a concern gathered and decided how they might react to it. In many professions, we have in my opinion become somewhat too concerned with credentials and less concerned with the issue of compassion and caring.

In your discussions around credentials, how have you aligned the need for, I guess, proficiency with the need for making sure that those who do enter the profession are the

aring, compassionate folks, who may not be able to get into university or perhaps go beyond the three-year general arts or science into a more specialized area, and who would probably make terrific midwives? That for me reflects back to sometimes wonderful people in communities who would make great social workers and who never become social workers because they cannot get their MA.

Ms Bevan: There is a curriculum development council on midwifery that has come up with a document basically talking about what you were talking about. We did not append this to our submission, but I am sure it is available.

The MTFO supports the recommendations in the CDC report, and as far as I know those talk about entry into midwifery being direct access, so direct entry into midwifery, and it being a very individual situation. Again, I am not well versed on this; I have read the CDC report but I am not an expert on it. But the impression I get is that when people want to become midwives, they are looked at on an individual basis for their criteria, for their—what am I trying to say? What is the word I am looking for?

Mr Martin: Suitability?

Ms Bevan: Yes, whether or not they will make good midwives, basically. On a personal basis, I am more concerned about my midwife being competent and being a good midwife than whether she can pass a pharmacology course or not. That is much more important to me, but that is just a personal opinion.

Mr Owens: The question I would like to ask is to legislative counsel through the parliamentary assistant. The two presenters touched on a very good point with respect to what the philosophy of this legislation is all about. I believe it was Michele who talked about the physician suggesting that for her second pregnancy, as she was post-caesarean, that a natural birth or a midwife would not be an option of choice. It confounds me since VBAC now is coming into the literature as the preferred method of delivery.

What is the ministry doing in terms of going to either the College of Physicians and Surgeons or communicating with the Ministry of Colleges and Universities to ensure that the philosophical change is going to occur at the training level and not hope that it percolates down to the doctors somewhere in the process, as they will be the persons left to assess who would be eligible to have the services of midwife?

500

Mr Wessenger: I will refer that to ministry staff.

Mr Burrows: I am not sure I can fully answer the question, because I am not particularly expert in this area, but my understanding is that this type of activity is in fact occurring under the aegis of the interim council. They are working at the educational program, for example. They are working at how the scope of practice might possibly be translated into practical terms. One would expect that once the legislation is passed and we have a transitional governing body, with the authority of legislation coming, there would be intense discussions between the newly to-be-regulated professions at the governing body level, the college level. It is not unusual for that to occur.

As an example with nursing, right now what happens is that the two colleges under the Health Disciplines Act, if there is a question about a delegated act, would be expected by the members of that profession to enter into a dialogue to come up with a suitable agreement that both professions could live with. One would expect that sort of respectful dialogue to occur.

Certainly with the declared policy intent of not only the current government but past governments behind this, one would expect there would be a great deal of popular support for that kind of process being a very meaningful and intensive one. Also, I would refer to the statements of the minister and the two former ministers at the time of second reading of this legislation, in which it was clear that the government is fully behind this activity and has the expectation that midwives would become full members of the health services delivery team. I think that is about all I can say, that they would have the full force of government policy intent behind those discussions.

REGISTERED NURSES' ASSOCIATION OF ONTARIO, REGION 2

The Chair: I call now the Registered Nurses' Association of Ontario, region 2, London, Huron, Perth, Oxford and Elgin county.

Ms Martin: My name is Anne Martin. I am the president of the Middlesex North chapter of the Registered Nurses' Association of Ontario, more simply known as RNAO. My fellow presenter today is Laurie McKellar. She is the chair of our political action committee. Today we are representing region 2 of the RNAO, which encompasses the Middlesex North, Middlesex South, Oxford, Perth and Huron chapters, or approximately 1,250 nurses. We thank you for this opportunity to address the social development committee on the Regulated Health Professions Act.

RNAO's mandate as a voluntary professional association for registered nurses is to lead the profession of nursing into full partnership in the practice and shaping of health care in Ontario.

RNAO believes that the principles of public protection and provider equality make the RHPA a cornerstone in health legislation in Ontario. This legislation will affect existing and proposed legislation, as well as institutional and community structures. However, it is imperative that the RHPA reflect current nursing practice and provide for the evolution of health services and provider roles.

Given the time restrictions today, we would like to concentrate on just two of our issues. We would refer you to our brief for our additional recommendations. The reason we have chosen these two areas of concern is due to the powerful impact these legislative barriers would have upon the present care we provide our patients.

First of all, I would like to provide you with a general view as to nursing's scope of practice:

"The practice of nursing is the assessment of the health status of the client, resulting in a nursing diagnosis, plan of care, implementation of the plan and evaluation of the outcome. The care may be implemented through means of support, health promotion, prevention of illness, advocacy, teaching or counselling, palliation, rehabilitation

and therapeutic intervention in order to attain or maintain optimal functioning."

Please keep this description of nursing practice in mind as we discuss the following urgent issues.

The first issue: "Communicating to the individual or his or her personal representative a conclusion identifying a disease, disorder or dysfunction."

In the act it is written that this is to be a controlled function. This must include a nursing diagnosis. A nursing diagnosis must not be confused with a medical diagnosis. A medical diagnosis is arrived at after analysis of a patient's clinical data and may require surgery, a prescription drug or other modes of treatment that are legally defined. This differs from a nursing diagnosis, which is an actual or potential problem-centred description of an unmet human need that requires nursing intervention. This process requires collecting, analysing, recognition of a pattern and validating clinical data, along with an individualized patient assessment.

Nursing diagnoses were designed to ensure high-quality patient care through the continuous application of theory and research-guided practice, the documentation and communication of effective or ineffective interventions and continuity of care by means of the development of an individualized plan for patient care.

For example, after a thorough patient assessment, collection of data, etc., a registered nurse has developed the following care plan for a patient who is assessed to be experiencing pain after surgery. Pain relief is a paramount concern in patient care, as pain can prolong recovery and bring on complications such as pneumonia and stroke.

The diagnosis: altered comfort level related to inadequate pain relief.

Our goal for this patient would be to obtain pain relief. The nursing interventions might include: to administer analgesic, or a pain killer, as appropriate; monitor and document pain quality, intensity and duration; collaborate with the physician to adjust analgesia dose, if appropriate. Expected outcomes for the patient might be that the patient would verbalize comfort and pain relief, report the ability to sleep, and we might note an increased level of activity.

Another goal for this patient might be to employ stress reduction or diversional relaxation to augment the analgesic effect. Nursing interventions might include: providing information about relaxation, guided imagery or diversional activities; teaching and monitoring the selected strategies; determining with the patient what activities precipitate or alleviate pain. Our expected outcomes for the patient might be that he would use music, TV and radio for diversion, use progressive muscle relaxation and collaborate with the nurse to evaluate the selected strategies.

From this example, we can see how a nursing diagnosis, with resultant interventions and plans for care, differs from a medical diagnosis and follow-up medical care. Obviously, this nursing plan for care is within the scope of nursing practice, independent of medical practice, and ensures the delivery of high-quality patient care.

Therefore, RNAO recommends that the act recognize diagnosis or communicating a dysfunction as a controlled act for each profession within the scope of their practice.

Our next issue can be located on page 3, under the Nursing Act.

In the Nursing Act, some authorized tasks for nursing are "on the order of a qualified person." This should be deleted from the act, as it threatens to interfere with prompt care-giving if the nurse is required to obtain an order to execute a task that is presently done independently and is fully within the registered nurse's realm of knowledge and expertise. These limitations are indeed a step backwards for health care at a time when the new vision on health strategy intends to remove barriers that prevent the more flexible use of health care personnel.

These restrictions hinder the nurse's ability to alleviate the discomfort a patient is experiencing when, for example, he is unable to clear his airways as a result of a lung infection and requires suctioning. Presently, it is within the nurse's domain to initiate suctioning if it is assessed to be necessary. However, if the nurse is required to get the order of a doctor, he or she would have to obtain the services of a physician. The physician in turn would be required to make his or her own assessment of the patient's condition and decide whether suctioning would be in order. Meanwhile, the patient continues to choke and suffocate on his own secretions. This truly is time that is wasted and puts the patient in a potentially dangerous situation. Bear in mind also the additional barriers to timely patient care for the nurse who cannot readily access a physician, like the nurse in a small community hospital or a outpost nursing station. As you can see, with these constraints it is indisputable that when the nurse's hands are tied, superior patient care is jeopardized.

The nursing profession has historically been fully accountable to the college and ultimately the public in conducting these tasks in the past. To restrict these acts is a departure from the vision reported in the Premier's Council report on health human resources, where it was emphasized that there is a pressing need for engineered change in the system and for better utilization of current human resources.

The Regulated Health Professions Act is important legislation which enshrines public protection and provider accountability. However, we cannot support this legislation as it stands. We believe it is a step backwards and as a result is a threat to the superior quality of patient care that the people of Ontario presently enjoy.

Once again, we thank you for the opportunity to present our concerns to you today and we would be pleased to discuss any of these issues now or in the future.

1610

Mr Hope: I am going to touch on a topic that you did not bring out, managing and conducting the delivery of a baby. I wish I could ask the midwifery this. We seem to determine whether it is the physician, the midwives or the nurses who are involved. I have to ask this question, because I was involved in the delivery of both of my children. Where do I play that role? As a father and as an activist who believes in being a part of birth, where is my role? It seems that the partner is being left out, and I would like to be a part of that. I enjoyed the two that I did have, but

ave to ask that question. Is it a battle of the professions, or are we forgetting about the spousal aspect of things too?

Ms Martin: I think the partner in delivery can be an assistant in some senses to the nurse in providing comfort measures and pain relief for the mother, so I think you do have a valuable part in the delivery process.

Ms Haeck: I appreciate your remarks. This morning I had a chance to discuss standing orders with some nurses in the hallway after we had had some long discussions about this with another presenter. You are basically concurring with their remarks, that you feel that standing orders or some of the other protocols that may be in place do not provide you with the kind of security in your normal job functions under this act or even as it presently exists. Am I correct in saying that?

Ms Martin: That is correct.

Ms Haeck: Those nurses, who are in fact still in the audience, indicated that what is currently happening is something called triage. Do you feel that the act in any way will give you protection in the process of performing triage?

Ms McKellar: I am not really prepared to answer that question.

Ms Haeck: If the hospital sets up a protocol which says that you, as a nurse, are in fact entitled to perform triage, will Bill 43, as well as Bill 57, provide you with the protection to deal with not just "on the order of a qualified person," but the whole process of performing patient care? Do you feel that there are protections in that protocol?

Ms McKellar: To perform triage?

Ms Haeck: Yes, by performing triage.

Ms McKellar: I honestly cannot answer that question at this point. If you like, I could look into it and get back to you on that one.

Ms Haeck: I would appreciate your remarks, because that is the way practice is going, then possibly the language of either act should be reflecting what is current practice.

Ms McKellar: Okay.

Mr J. Wilson: It certainly is an excellent brief, especially the couple of real-life examples you gave us about what nurses do in their day-to-day functions.

I gather the review committee must have deemed as emergency cases such as suctioning, in the case of the congested fluids that you mention in the example, and put a provision in the act to allow for emergency cases. I just want to give you the opportunity to clarify that. I find that rather demeaning to nurses, that it would have to be an emergency before you are allowed to perform your duties. Does that at all reflect what you do now? I have to admit, a number of the examples that have been given in this committee seem to be emergency situations. Can you just elaborate on that?

Ms Martin: In this case, where we have given you the example of suctioning, where I work, in an intensive care unit, it is an hourly thing with some patients, and to have to go get an order each hour to suction a patient is a little ridiculous. I understand that for any patient who is intubated with a breathing tube, etc, or experiencing respiratory

difficulties, we could have a standing order to suction, but why would we need it when up till now we have been doing it independently and we are fully accountable for our actions? So it just seems to be a step backwards.

Ms McKellar: Many times, when someone initially needs suctioning, it might not be in an emergency situation, but if you leave it for too long it could very definitely become an emergency situation, and you have further repercussions on other parts of the person's body.

Mr J. Wilson: I expect the legal repercussions would be you would have to prove that it was an emergency situation.

Ms Martin: Possibly.

Mr J. Wilson: The onus of proof, as the act reads, would be on you.

Ms Martin: You mean if we went ahead and suctioned?

Ms McKellar: Without an order.

Ms Martin: Yes.

Ms McKellar: As the act stands now, yes.

Ms Martin: It could be a problem proving to them that we in fact thought it was an emergency situation.

ONTARIO ASSOCIATION OF SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS, LONDON CHAPTER

Ms Bandur: My name is Donna Bandur and I am president of the Ontario Association of Speech-Language Pathologists and Audiologists. I am addressing this committee today as a practising speech-language pathologist in London and represent our professional regional chapter, along with Brian Field, a practising audiologist. I will devote the first portion of our presentation to address concerns regarding title restriction, diagnosis and the use of the title "doctor." Brian will close with a discussion relating to the controlled act "prescription of a hearing aid."

Speech-language pathologists and audiologists in our region strongly support the principles of this new legislation. The public is without question entitled to quality care with a mechanism in place to ensure the competence of the service providers. Those suffering from communication problems are particularly vulnerable and perhaps are those most in need of protection to ensure that their rights are exercised and that their needs are thoroughly addressed. They may not be capable of asking the right questions or perhaps of understanding their answers. When I speak of that, I speak of people who may be neurologically impaired, so that their speech musculature is paralyzed or they may have difficulties in comprehending speech due to stroke. It is therefore of paramount importance that appropriate safeguards are in place to protect these disadvantaged persons.

To this end, I raise some concerns regarding the legislation as it is currently proposed. First, it is recommended that Bill 44, subsections 15(1) and (2), outlining the use of the title "speech-language pathologist," be expanded to include the title "speech therapist." Because the general public equates these two terms, there is risk that persons seeking speech-language intervention would not necessarily differentiate between practitioners and their qualifications,

thereby failing to make informed choices. We also urge that the phrase "in the course of providing health care" be removed, as it further limits the protection of the public. Many speech-language pathologists and audiologists are employed outside of traditional health care settings. They may work in private practice, education or industry. Title protection is just as, if not more, essential in settings where medical models of service delivery are not utilized. As well, the importance of a stronger holding-out clause is urged. Use of terms such as "audiological services" and "speech-language pathology services" would quite naturally lead one to assume that these services are provided by qualified audiologists and speech language pathologists.

1620

With Bill 43, subsection 26(2), speech-language pathologists and audiologists would be prevented from continuing to provide a most essential component of their service continuum. Following often very lengthy detailed assessment procedures, individuals expect that a thorough interpretation of these results will ensue. It is our strong conviction that those professionals with the most comprehensive knowledge of these tests and their interpretation be the ones to convey the appropriate information. Persons who have limited communication skills require careful, sometimes simplified explanations in order to understand and begin to adjust to the symptoms of their conditions. Speech-language pathologists and audiologists receive specialized training in communicating with those who cannot express themselves through speaking or writing, and may have very limited understanding of spoken or written information.

In my own clinical practice, I see victims of stroke daily who are devastated and frightened by their loss of communication. They, and their families, have specific and ongoing questions regarding their deficits, and are relieved when I can provide easily understood explanations in a timely manner. This may necessitate my speaking slowly with simplified grammar and in shorter sentences. It may require the use of drawings and gestures to supplement what I say. Whatever approaches I do use, however, depend on the specific communication problems of that particular person. To refer their questions to someone with less information, and less skill in conveying that information, would compromise the quality of care by adding more stress and confusion to those already experiencing considerable loss.

Finally, I would like to offer my concluding comments on Bill 43, section 30, restricting the use of title "doctor" to five professional groups. I have many colleagues who have spent years in advanced training to earn their doctoral degrees. To disregard their PhDs, while at the same time recognizing those of others, would be a failure to acknowledge their professional contributions and would result in an atmosphere of inequity. I ask that the committee reconsider this exclusion in order that audiologists and speech-language pathologists holding doctoral degrees are able to use the title "doctor." I would now like to offer Brian the opportunity to conclude our presentation.

Mr Field: This committee has listened to a number of presentations and read many briefs concerning the prescription of personal hearing aids. No doubt there is much

more to come. To date, three major concerns have been raised about the proposed legislation. It has been suggested that changes in the legislation will: (1), reduce public access to hearing aid services, specifically in non-metropolitan areas; (2), will substantially increase the overall cost of Ontario's health care system; (3), will result in a gold-plated system, because lesser-trained individuals could prescribe hearing aids quite competently with no risk. I will limit my presentation to these three points.

1. Public access to hearing aid services: Concerns have been raised that limiting prescription of a hearing aid to audiology and medicine, and separating authorizing and dispensing, is causing, through the limitations now in effect through the assistive devices program, and will continue to cause, major access problems for people who need help. A previous Association of Hearing Instrument Practitioner presentation outlined a drastic picture suggesting extensive waiting lists in the province for audiological services and poor access to the services in non-metropolitan areas while implying that its members provide the majority of services in these areas. The submission by the Ontario Association of Speech-Language Pathologists and Audiologists, OSLA, to this committee on August 12, 1991 in Toronto contains the report access to Audiology Services 1990, appendix 9.4 in the OSLA brief. The data was provided by the assistive devices program, the Workers' Compensation Board, the Department of Veterans Affairs, as well as our own research.

To summarize, this data shows: 71% of hearing aid authorizations in Ontario are currently provided by audiologists; 65% of all ADP hearing aid authorizations are provided by audiologists; audiologists authorized the majority of claims in both metropolitan, 62%, and non-metropolitan areas, 72%; audiologists provide the majority of hearing aid authorizations in traditionally underserved areas such as the northern, 72%, and eastern, 64%, regions; the average waiting list in Ontario for a hearing aid evaluation is 3.6 weeks; the majority of claims authorized by non-audiologists, 73%, occur in metropolitan areas.

It is clear that the majority of hearing aid authorization services currently provided in the province are done by audiologists. It is apparent that, despite AHIP's statement to the contrary, the major contribution to access made by non-audiologist authorizers is occurring in metropolitan areas where access to audiology services has never been considered problematic. AHIP has emphasized an attrition of non-audiologist authorizers and service clinics since the expansion of the ADP program in January of 1989. Despite the number of service clinics which were reported to have stopped operating since January 1989, in all instances, with the exception of one community, services remained available in the community. And that is shown to you in appendix A.

At the time, new ADP regulations were being introduced. Many of the statistics and research now available had not yet come to light. As a result, the grave concerns about access to service were understandable in the late 1980s. To try to eliminate any potential loss of service and to protect livelihoods, ADP, with the agreement of OSLA and AHIP grandfathered about 180 hearing aid dispensers who authorized and dispensed hearing aids before January 1989.

these individuals could continue to provide both services after passing a competency exam. In light of factual information concerning access to both authorizing and dispensing services, the executive director, consumer services division, Ministry of Health, recently made the following statement: "After reviewing the information presented by the associations"—that is, AHIP and OSLA—"represented at the November 1990 meeting, the assistive devices program data on hearing aid authorizations and sales, and information collected from other sources such as district health councils and Ministry of Health field offices, we have concluded that there is not currently a significant problem in accessing hearing aid services across Ontario." That letter is in appendix B for you.

2. Cost of audiology services to the health care system: It has been suggested that as a result of this provision, costs to the health care system will increase dramatically, particularly the OHIP billing costs associated with audiology services. This issue requires clarification. OHIP is a payment scheme for physician services in both private practice and in hospitals. Audiology services, under OHIP, both in hospitals and in private practices, are delegated medical acts. As such, 40% of these OHIP billings are paid by physicians for their supervision of other individuals providing billable audiology services: nurses, audiologists, those whom they may employ. The remaining 60% is paid to the physician to cover the cost of equipment, space, and to pay the person who does the testing. Thus, attributing OHIP billing costs specifically and entirely to audiologists is misleading.

The fact is 80%, 200 of the 250 audiologists practicing in Ontario, are salary employees working for public institutions. The average salary of an audiologist is \$45,000 per year. The remaining 50 are employed by physicians in private practice settings. Once audiologists are legally regulated in their own college, any need for direct medical supervision falls away. This transfers the responsibility for assessments performed by audiologists from the medical doctor to the audiologist, where it belongs. The stage is then set to eliminate needless OHIP payments. We believe the cost of providing audiology services could be significantly reduced. With respect to future funding, particularly in non-institutional or community based settings, OSLA supports alternative funding methods that would allow for future service developments outside of the traditional fee-for-service format. This step would seem a logical extension of the legislation, and is consistent with the intent of the legislation to "permit the evolution of a more flexible, rational and cost-efficient health care system."

530

3. Risk of harm: The inclusion of prescription of a personal hearing aid as a licensed act is certainly justified by risk-of-harm criteria. It is essential to realize that the prescription of a correct hearing aid is but one component of the comprehensive program to help patients. Prescription of a personal hearing aid is one outcome of the proceeding assessment and diagnosis, and must be undertaken with appropriate counselling and guidance as well as the provision for other rehabilitative strategies, including auditory training, speech reading, teaching social strategies for

dealing with hearing loss, or the selection of supplementary or alternative listening devices. Prescription of a personal hearing aid is not a discrete technical act but rather a process which relies on significant technical expertise, combining the results of assessment and diagnosis with an individual's social, emotional, and physical needs and/or limitations. By virtue of training, an audiologist is in a position to accurately determine needs on an individual basis, and to produce an appropriate prescription, if necessary. Audiologists are not dictators who say, "This is the hearing aid you must have." We try to take into account the patient's needs in a holistic approach, listen to what is important to them, and then try to direct them to the device that is going to properly fill that need.

As indicated in previous submissions, audiologists are the only group of health care professionals who receive specific training in both the assessment and rehabilitation of hearing disorders and dysfunctions. This is of utmost importance, particularly in determining the need for further medical follow-up; for example, in case of unilateral, sudden or conductive hearing loss. And there I am talking about misdiagnosis of problems.

Summary: The licensed act of prescription has been debated, using arguments about the presence of physical or emotional risk of harm, resulting access difficulties and resulting cost impacts. The existing legislation only ensures that a hearing-impaired individual considering use of a hearing aid is assessed by either a physician or an audiologist in the province of Ontario. This provision in the legislation offers consumer protection and lays the groundwork for a more rational, cost-effective hearing health care system without compromising access to service.

Mr J. Wilson: Just to play devil's advocate for a minute, a number of members of the provincial Parliament have received letters from constituents, normally older constituents, who indicate they are quite happy with the service they are now receiving from hearing-aid dispensers. They tell us they do not want us to force them to have to go to an audiologist or an MD prior to receiving hearing-aid services. For the record, what do we say to them?

Mr Field: What is our concern? The concern is that a serious medical problem could be missed. Such items as an acoustic neuroma, or cholesteatoma, are hidden items in a simple assessment that would not be noticed by someone doing an assessment strictly for the purpose of fitting a hearing aid. If those items go undiagnosed it could result in death. Both of those are life-threatening disorders. The earlier they are caught the better. Audiology is one of the first-line defences against those two particular pathologies.

Mr J. Wilson: But have we had documented cases of harm for people that have been misdiagnosed?

Mr Field: Been misdiagnosed? There is lots of it in the literature.

Mr Beer: One of the other issues that has arisen from consumers in the survey—we have had a number in the hard-of-hearing community who have indicated the problem if their hearing aid is lost or broken or whatever and they are not in a community that has an audiologist. If they cannot

get access to a new hearing aid quickly, it can have a very dramatic impact on their job and their working conditions.

How would you see that sort of situation evolving? Let us suppose I lived in a community that did not have an audiologist. I had been assessed, fitted. How would I be able to get that quickly under the proposed legislation?

Mr Field: It is pretty much standard practice currently that anybody who dispenses hearing aids has a set of consignment aids or loaner hearing aids that are available to individuals if their hearing aid suddenly breaks. For example, if your hearing aid just broke down, it usually takes about two weeks for a hearing aid to be sent into the manufacturer, repaired and returned. That is average. The same problem exists over those two weeks. How does one handle not being able to hear over that time? Usually loaner hearing aids are available from any dispenser. One possible way to handle it is through a loaner hearing aid, until such time as a new assessment and prescription can be undertaken.

The other thing, of course, is how current does an assessment need to be, to require a new assessment before a prescription is made? The standard practice now, at least in my practice, is that if it has been more than a year I consider that I should reassess their hearing before prescribing a new hearing aid, so if there has been a change in their hearing that can be incorporated in the new hearing aid. If we based that on last year's results, and if they have lost their hearing aid in the intervening time, I may well prescribe an inappropriate hearing aid for them.

Ms Haeck: To follow up on Mr Beer's comments, we have had those consumers out there saying that they have felt that the audiology community, the profession as such, has possibly not been as responsive to their need for a variety of hearing-aid appliances. Any comments?

Mr Field: Do you mean by that other items as well as their hearing aids; other assistive devices that they might wish to use?

Ms Haeck: That there is a range. One gentleman says that he has about eight different appliances that he may or may not use. Other consumers have felt they have been dictated to about their type of hearing aid, without really having access to a broader spectrum.

Mr Field: I think on closer examination you would find that audiologists are probably the most well-versed group of professionals about assistive listening devices. That is part of our training. We are not trained to know only about hearing aids.

One of the important aspects about prescribing a hearing aid is to find out what other areas of difficulty an individual has, what hearing aid might be compatible with other assistive listening devices they might require, such as an FM system or external microphones or other things? If, in fact, a wrong hearing aid is prescribed that is not compatible with some future system that they might require, that has been a poorly prescribed hearing aid. The way I have been trained is to look at the whole person's needs. If I can see any reason why they might require such an assistive device, I make sure they understand that for that reason we may need to go to this type of hearing aid so it will be compatible with that particular device. That is part of the assessment.

Ms Haeck: Now, this person was specifically concerned around a lifestyle issue. Someone who needed an FM system was given a prescription for something in the ear and, in fact, it did not work. That was only option he was given by the audiologist as opposed to something else.

Mr Field: I cannot answer what the audiologist might have seen in that case. I do not know. Certainly that is not normal.

The Chair: Thank you very much for your presentation. We appreciate your appearing before the committee today. I know you realize that if there is additional information, you can submit it to the committee at any time in the course of our hearings.

Mr Field: Thank you very much.

The Chair: The committee officially stands adjourned until 9 am—please note 9 am—Monday morning in Ottawa.

I have some housekeeping for committee members. Cabs to the airport will be outside at 4:45 sharp. They are grey. There will be three members to a cab and the clerk requires your air stubs from your tickets, which she will collect at the airport. Any additional information you can ask for yourself.

The committee adjourned at 1638.

CONTENTS

Thursday 22 August 1991

Regulated Health Professions Act, 1991, and companion legislation / Loi de 1991 sur les professions de la santé réglementées	
et les projets de loi qui l'accompagnent	S-577
Ontario Society of Clinical Perfusion	S-577
Chinese Medicine and Acupuncture Association of Canada	S-579
Health Care Aide Association of Ontario	S-581
Ontario Osteopathic Association	S-584
Don Boksmen; Vikki Paquette	S-584
William Reid	S-586
Dennis Lebert	S-587
Debbie Carroll	S-589
Thomas Scheid	S-591
David Breznik	S-592
Dale Vellet	S-595
Harry Banks	S-595
Tom Hebert	S-597
Barbara Conlon	S-598
John Galbraith	S-601
Terfaith Pastoral Counselling Centre	S-602
University of Waterloo School of Optometry	S-605
London and Area Association of Optometrists	S-607
London Regional Psychological Association	S-610
Ontario Association of Social Work Administrators in Health Facilities	S-613
London Birth Centre Committee	S-615
Midwifery Task Force of Ontario, London Chapter	S-618
Registered Nurses' Association of Ontario, Region 2	S-621
Ontario Association of Speech-Language Pathologists and Audiologists, London Chapter	S-623

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First Session, 35th Parliament

Official Report of Debates (Hansard)

Monday 26 August 1991

Standing committee on social development

Regulated Health
Professions Act, 1991
and companion legislation

Assemblée législative de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le lundi 26 août 1991



Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent

Chair: Elinor Caplan
Clerk: Lynn Mellor

Présidente : Elinor Caplan
Greffière : Lynn Mellor

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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with an alphabetical list of members of the Legislative Assembly of Ontario.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste alphabétique de députés de l'Assemblée législative de l'Ontario.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 26 August 1991

The committee met at 0859 in the Delta Hotel, Ottawa.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44-64, qui l'accompagnent.

ALLERGY AND ENVIRONMENTAL HEALTH ASSOCIATION, OTTAWA BRANCH

The Chair: The standing committee on social development is now in session. I would like to welcome everyone this morning. I call as our first presenter, the Allergy and Environmental Health Association. You have 20 minutes for your presentation. We would ask if you will leave a few minutes at the end in case any of the committee members have any questions. Please begin your presentation now.

Mr Brown: Thanks very much, Madam Chairman, and thanks very much to the committee for this opportunity to talk to you. I am speaking on behalf of the Ottawa branch of the Allergy and Environmental Health Association. This is the largest branch of our association in the province—we have about 300 members—and we are also the largest per capita branch of the association.

People with environmental sensitivities are people who react to substances in the environment at levels of exposure that do not affect most other people. George Thomson, who is now Deputy Minister of Labour, who I am sure is familiar to all of you, did a report in 1985. In his report he listed symptoms involving every system of the body, with effects ranging from mild discomfort to serious disability. For some people, environmental sensitivity is an annoyance. For the more seriously affected people, it is a disabling problem.

We have achieved some progress, thanks to some of you, and thanks to people in human rights commissions and so on. The most recent thing that I would like to inform you about is a letter from Marion Boyd, Minister of Education. She writes that her ministry now agrees that environmental sensitivity should be considered as a possible contributing factor in learning disabilities and behaviour problems in schools, so school boards should take this into account when applying the Education Act, and meeting children's special needs.

Environmental sensitivity is not an illness. It is a phenomenon of reacting to substances, as I have described, which can be caused by a wide variety of illnesses. Some of them are well understood. Others are not well enough understood for medical intervention. The only method of

treatment that people know of is avoidance of sensitive substances. The problem is not new. I mention a couple of these things because there is a lot of mythology in the media about this problem, and in some other circles.

Environmental sensitivities have been experienced for generations. They are not new to the medical community either. Medical literature goes back for a couple of centuries. The Department of National Health and Welfare published a bibliography a couple of years ago with hundreds of articles dating back decades. The information is not hard to find. Within an hour of being diagnosed in 1979, I was reading a book on the subject in a library. The book was published in 1951, so this is not a new problem, and it is not new to medicine.

Just a bit of background about our association. We are the largest of five self-help groups in Ontario. Our main activities include self-help, helping people deal with lifestyle changes required for dealing with this problem, dealing with employers, dealing with various authorities, and helping people, for instance, with human rights concerns related to having this disability. Most of our activities in the Ottawa branch relate to helping people deal with adverse differential treatment by Community and Social Services, Ministry of Health, and authorities outside the provincial purview.

There are a number of attachments. I mentioned the letter from Marion Boyd. There is also the last page of a letter from Darlene Koski, president of our association—which had a different name in 1984—talking about suicides of people caught in this adverse differential treatment in the health community. There is a letter from the coroner relating to a suicide of a person who was told by the Ministry of Community and Social Services that his problem was all in the mind; a letter from Catherine Frazee indicating her willingness to help the Ministry of Health deal with some of the attitude problems on this illness; a statement of the federal human rights commissioner talking about some of the abuse that people with this problem experience.

Most of the concerns in the Ottawa branch relate to adverse differential treatment. This relates quite closely to this legislation, because it is something that I think consumers should have recourse about. A lot of these problems have stemmed from the fact that over a period of time various authorities said that persons with this problem did not have a legitimate medical problem—that their symptoms were all in their mind, that these people were so crazy they were making themselves sick, and so on. In other words, statements were made which had a negative effect on the people's reputation for soundness of mind, their credibility as professionals, their expression of special needs within the community with landlords, employers, and so on.

This statement was made on the expressed reason of not understanding the physiology involved. I would suggest,

and I think you would agree, that it is inappropriate to make statements which reflect poorly on people's credibility, and on their reputation, when those statements are based on an absence of information. In order to make statements that hurt people, one requires evidentiary reason, due process and opportunity to respond. Such statements should not be made on the basis of an absence of information, or on the basis of people having a particular disability.

This is what happened, and there were a number of consequences which I would like to mention, and then discuss how this relates to the legislation that is proposed. The first of the consequences—and these consequences go from the least important to the most important for the three that I will list—relates to the actual damages that were caused to people by the fact that this statement was made. The insult was more damaging than the injury that it was added to. Families broke up. Professional reputations were ruined. People did not receive benefits. People were caused increased disability by doctors who ignored their concerns. A number of people were killed. As I mentioned earlier, there have been a number of suicides of people who became frustrated with the health-care system, with the way officialdom was dealing with them, and with the fact that small things they needed, which were manageable, became impossible to deal with because of the attitude pollution around.

As bad as the first problem is, the second consequence is worse. We are a community of people who have been abused in the way that I have just described. Many of our people have had their careers ruined. And many people involved in this issue have friends who have either been caused disability unnecessarily or who have, in some of the extreme cases, committed suicide.

Material evidence relating to this concern has been brought to the authorities for some time. There has been some action towards research. There has been some action in Community and Social Services recently, and in Housing. But the abuse in the health care system has not been addressed. As a result, the people with this problem, the people coming forward, are coming forward with a very heavy emotional load, usually with a victim mentality. Our community is very fractured as a result of the tension which results from this kind of treatment. At the one end, we have people whose rage is not understood by others. At the other, we have people who may be financially independent who are trying to appease the bullies.

Between these two factions, and with a lot of other tension in our community, the second consequence I want to mention is that we have a problem as a community bringing forward a coherent statement of our concern, with an integrated representation. There are about five self-help groups in the province and, to be frank, there is a lot of tension. I think that sometimes the authorities have been confused by receiving conflicting messages from the various parts of our community.

The third consequence is worse. It is that the very authorities now in a position to help us—this includes some of the professionals covered by this act, some parts of the Ministry of Health, and some other parts of provincial government—are the authorities that have participated in or tolerated or

been compliant with the abuse. For these authorities to act now in a forthright manner, to speak the truth about the abuse, to act on the concerns that people have, would be an implicit, in some cases an explicit, acknowledgement that what has been done to this group is unethical. It is not just that it caused damage, but that it is unethical.

0910

I want to emphasize, underline and put in bold letters that our organization is not bringing forward the issue of compensation. We are not looking for a witchhunt. We are simply trying to identify the political logjam that is preventing a constructive resolution of concerns on this issue.

If I could be permitted one quick aside, I will come back to relating what I have just said to the legislation. There is a strong likelihood that many psychiatric patients have undiagnosed sensitivities as the cause of their problem. Thomson relates a list of central nervous system symptoms which are listed here. Perrin Beatty, when he was Health minister, wrote us acknowledging support for the United States study which won a World Health Organization award which strongly recommends checking for environmental sensitivities before embarking on potentially detrimental psychiatric interventions. The authors of this study, done for the New Jersey state department of health, are Ashford and Miller, a doctor of jurisprudence from the Massachusetts Institute of Technology and an immunologist from the University of Texas.

The focus in the Ministry of Health has been on conducting more research. I would suggest that when you have this kind of recommendation, and when the practice of screening psychiatric patients for sensitivities is not in place, you have a very, very strong likelihood, a virtual certainty, that some percentage of psychiatric patients should not be psychiatric patients but should be treated for environmental sensitivities. We would say that this group of people is being abused by the health care system, including by the mental health facilities branch of the Ministry of Health. That is an aside just to emphasize the importance of forthright action on this concern, and the importance of getting people out of the frame of bobbing and weaving to avoid acknowledging previous abuse and to get on with dealing with this problem.

I mentioned that the focus has been on research. If you see somebody down the road from your house, a kid being beaten up repeatedly or some other form of abuse—it is very useful to encourage research, but I think the onus is on the authorities to stop the abuse. I do not think that the government has acted on that. I think the government has a debt, given the previous encouragement of this attitude by the Ministry of Health.

With respect to the legislation, when there is widespread abuse in a profession—for instance, when there is toleration in the medical profession of dismissing consumers' concerns as being all in the mind when people are dying because of this—there should be some means of appeal around that profession. It should not be necessary for the consumers to go to a college representing that profession's interests. Even if we acknowledge that there is an interest in the College of Physicians and Surgeons of Ontario to have good medicine in the province, it should

not be the case where people being abused by a profession have to go to a self-regulatory agency to make their case. There should be some formalized institutional process of being able to go directly to their representatives, in this case representatives in Queen's Park and probably in the Ministry of Health, to deal with ethical and human rights concerns, which surely should take precedence over medical treatment.

The other elements I have in the brief relate to the action about controlled acts, I think it is subsection 26(2), and paragraph 26(2)13 relates to allergy testing. It was a little confusing to us why there was what seemed to be arbitrary specificity here, a level of specificity in regulating allergy tests and singling them out for regulation. That is a question there may be a good answer to, but there are a couple of concerns, if it is there, that I think you might want to address.

One of them is that there are many different kinds of sensitivity besides allergy, and if you are going to single out allergy you might want to single out all kinds of sensitivity, including allergy and non-immunological types of sensitivity. Reactions to toxicological sensitivity and food intolerance, for instance, which are not allergies, strictly speaking, might be covered in the legislation. The other element of that sentence relates to the fact that the type of test that is being controlled is where the positive indicator is a reaction of an allergic type.

So two points again: One, what if the positive indication is a reaction of a non-allergic type, which is life-threatening? In other words, if you are going to protect some of the members of the Allergy and Environmental Health Association of Ontario, the ones who have allergies, why not protect all of them, the ones who have other kinds of sensitivities? The second part of that is the idea that quite often a positive result of a test is not a reaction. For instance, serial dilution titration testing recommended by Thomson in 1985, the positive reaction of the test is a neutralization of symptoms. However, a positive reaction can be used on the route to finding a neutralizing shot or sublingual dose. So if you are going to protect people with allergy, why not protect a broader group of people with sensitivities? If you are going to protect people from tests where the reaction is an allergic reaction, why not protect them from tests where there are toxicity reactions? If you are going to protect people from tests where the reaction is positive, where a positive indication is a reaction, why not protect them from tests where a positive indication is other than a reaction, but a reaction may be caused during the course of the test?

I think that is all I need to put in a summary. Thank you.

Mr Grandmaître: In your brief you are saying that environmental sensitivity is not a medical illness, but sensitivities can be caused by a number of illnesses. You were diagnosed in 1979. Tell me about your life before 1979. Were you struck with some kind of illness?

Mr Brown: I would rather avoid a description of my personal situation. I had this problem all my life. I went to a variety of specialists over a long period of time to find out what the problem was. Finally in 1979 I was fortunate enough to come across some British work on this subject and to find a doctor familiar with it and to be diagnosed. I

had medical problems before 1979, but I want to emphasize that the difficulty people have is more with the stigma attached, with the fact that they have been trashed on the basis of an absence of information. That is where the difficulty lies. In terms of this legislation, the concern is to try to give people an option for appeal other than going to the parties who are aligned with those who are carrying out the abuse.

The Chair: I want to thank you very much for your presentation this morning. The committee has received your written brief, and I would inform you and anyone else who is listening this morning that if there is additional information you think would be helpful to the committee during its deliberations, please submit further briefs and information in writing through our clerk. Thank you for appearing this morning.

0920

ONTARIO NATUROPATHIC ASSOCIATION

The Chair: I would like to call next the Ontario Naturopathic Association. Please come forward and introduce yourselves to the committee for the purpose of Hansard. You have 20 minutes for your presentation, and if you will leave a few minutes at the end of your presentation for questions we would appreciate it. The committee has received the three written briefs you submitted. Please begin your presentation now.

Ms Rivard: My name is Darcelle Rivard. Je suis ici ce matin pour dire quelques mots au sujet de la naturopathie. Je vous remercie d'avance de prendre le temps de m'écouter.

Good morning. I am a graduate of the Ontario College of Naturopathic Medicine. I am a full-time practitioner of naturopathic medicine in Timmins. I have a diverse practice providing naturopathic care to francophones, English-speaking citizens and members of the first nations. My services are utilized by many people living in northeastern Ontario, including Kapuskasing, Iroquois Falls, Cochrane and Matheson, to name a few.

I entered this profession to help people be well and enjoy their years free from suffering and illness. If I am unreasonably restricted or held back from using the basic skills and training I have worked hard for, I will actually be forced to move away to practise the career that I love. Please understand that neither I nor my colleagues want to expand our scope to be medical doctors or anything else other than doctors of naturopathic medicine. However, we also do not want to be reduced to a level of practice that does not use our training and our skills.

I spent many years reaching this level of training and I believe it will be wasted if our scope of practice is eroded. I would like to thank you for this opportunity to express my feelings on this important matter. Since I am a relatively new doctor of naturopathic medicine, I have therefore invited Don Warren, an experienced colleague of mine, and a patient of his, Margaret Smiley, to complete this presentation.

Mr Warren: Good morning. I am a full-time practitioner of naturopathic medicine here in Ottawa. I am also a member of the board of directors of the Ontario College of

Naturopathic Medicine as well as being a professional member of the Ontario Naturopathic Association.

You have had several presentations from our profession, from the Ontario Naturopathic Association, so what I would like to do this morning very briefly is give some details to the background of the training of a naturopath and really what kind of implications new legislation will have upon our college in Toronto.

The Ontario College of Naturopathic Medicine is the only Canadian college recognized by the licensing jurisdictions of various Canadian provinces and the various states in the United States that license naturopaths. To become a naturopath requires three years of pre-medical training at a recognized university and then four years of training at a recognized college of naturopathic medicine. Along with the basic medical sciences, we are trained in the clinical sciences of botanical medicine, clinical nutrition, homeopathy, oriental medicine and acupuncture, naturopathic manipulation, physical therapy such as heat and light, electricity, and hydrotherapy. We are also trained in the areas of radiology, in clinical and laboratory diagnosis, including venepuncture. We are also trained in minor office procedures.

This range of training is consistent with the scope of practice of the licensing requirements of the various jurisdictions that license naturopaths in North America. Our students are given a complete and broad range of training in subjects and methods that are not taught to any other health care provider in Ontario. We use time-proven, effective, non-invasive low technology in most cases, very gentle forms of medicine that actually work and have been proven by years of use, not only within our culture but in other cultures over many years.

We are also interested though in what is happening on the latest fronts within science, such as the discoveries of immuno-modulating natural substances that help stimulate the immune system. So we are an eclectic combination of things that are time-proven, and we are trying to keep abreast of what is happening in science in the areas that fit our principles and scope of practice.

There is also, obviously, a natural overlap between our training and other health care providers, including that of medicine. However, as was mentioned by Darcelle earlier, we have no interest in encroaching on any other health care provider's territory or turf. We feel we offer a unique set of services that we are trained in. This is what we want to be able to continue to give.

The Ontario College of Naturopathic Medicine has become and is becoming a world leader in training competent and well-trained naturopathic practitioners. The success and growth is indicative of the increased public demand and public interest.

As an aside, I have been practising for four or five years. I left a career in business and the family business here in Ottawa, went back to the University of Ottawa, did my pre-medical science training there. Then I had to go to the United States, because in 1979, we did not have a college in Canada. I studied at the National College of Naturopathic Medicine in Portland, Oregon. On graduation it was something I was very excited about, coming back to practise here in Ontario, because I knew we had a law that

permitted us with a reasonable scope of practice. I had great fears when things started to go in an opposite direction. However, with the work of the previous government and the present government, I feel much better about the future of naturopathy.

What you do as a government will affect whether we as a college continue to be a leader in natural health care training. The public demand is there. I have been practising only for four or five years, but at this point, I have about a year's waiting list of patients who are chronically ill. Certainly, if a person was acutely ill we would see them. But a patient who is chronically ill takes about a year to get into our practice. This is just by word-of-mouth referral. So there is a great need for well-trained, competent naturopathic physicians or practitioners here in the province.

Your law will affect what we are able to teach. What we are able to teach will determine what students we will be able to attract. If our scope of practice in Ontario is such that we can train students to go and practise in BC or other provinces, then we will keep our students here in Canada, otherwise we will lose them to the States. We also have a great opportunity to attract students from the eastern seaboard in the United States to our school.

So we appreciate you listening and we hope you will continue to give this study. The future of our profession, the future of our school, depend upon the details and scope of practice that will come out of this legislation and future legislation. Thank you very much.

Ms Chalin Smiley: I am here as a private citizen and as a patient of a doctor of naturopathy. I am here to seek your support in ensuring that I continue to receive the full scope, range, of treatment I have been receiving. I understand that under the new law the naturopathic profession will have to apply to define its scope and range of services. I am really concerned that I continue to receive this without having to leave my home province.

About a year ago I could not walk from where I am now to where you are without tremendous difficulty and without total exhaustion. I sought out naturopathic treatment on the advice of a colleague. From the very beginning, my condition improved dramatically. I received the range of treatment that Dr Warren has described, particularly the homeopathic remedies, which I found to be extremely effective in my condition. Now I can exercise, I can ski, skate, swim, rollerblade—I do everything. At that time the prognosis was not good. It was not expected that I would be able to return to my job full-time. I now am working as a senior manager in the federal public service. I have energy. I have excellent health and I really attribute it to my visits to my naturopath.

The treatments are non-invasive. I was told to expect a lifetime of drugs, possibly surgery. When I was in the hospital—I was in the hospital for over a month a year ago—I was subjected to all kinds of treatments. I was receiving 1,000 cc of steroids, prednisone, by intravenous drip. So I had a fairly serious condition.

My doctors are amazed. They are very enthusiastic. They are extremely supportive of my homeopathic treatment. In fact I have not had steroids since last fall. And I have a consulting neurologist, a rheumatologist and my general

practitioner, and all three of them are very supportive of my seeking this treatment.

930

Mr J. Wilson: Thank you for the presentation, Ms Smiley. You mentioned in your brief, I think, that you hope that this committee does not leave the naturopathic scope of activities at the mercy of the system without comment. My question is better addressed to the parliamentary assistant. What exactly will be the process for defining the scope of practice for naturopathic medicine? It is my understanding that the advisory council will be doing that. Certainly it is not really the purview of this committee at this time. Perhaps you would like to comment on that.

Mr Wessinger: Yes, it will be the advisory committee but for more details I will refer it to the staff.

Ms Bohnen: The advisory council will be created as soon as possible after the legislation completes its course in the legislative process. The bill sets out a skeletal framework for the advisory council. For example, no regulated health professionals will sit on it, largely to ensure that it will take an impartial, objective look at the matters that are referred to it. The advisory council will have to have a support staff, a full-time secretary, information available to it, and will have to determine its own procedure and its own criteria in considering matters such as this.

The Chair: Supplementary question, Mr Wilson?

Mr J. Wilson: Perhaps one of the two doctors of naturopathic medicine could let us know now—what are some of the key things you will be looking for in a defined scope of practice, that you want to make sure they do not leave out?

Mr Warren: Certainly there are some things in Ontario that we are hindered in under the Drugless Practitioners Act. In fact, in many ways it has been an obstacle to us in being able to perform as we are trained. One of the things that we are concerned about is the access to the labs. Although we have the opportunity of taking blood, venuncture, we do not have any labs that will take our work because we do not have that covered in our scope, so we are limited in some of the diagnostic aspects. There are other areas such as radiology. We want to make sure that we have the ability to continue to take and read X-rays. Particularly in diagnostics, the area of laboratory diagnosis, is very important we have that so we are able to be complete. Where I trained in Oregon, we had a much broader scope of practice, especially in that regard. In other jurisdictions, such as BC, they have this scope of practice. We want to be able to ensure that this happens here in Ontario.

Mr Beer: I sense one of the points in the collection of our briefs is whether as a committee we have the right or are likely to comment on this particular issue. The committee is free to comment on anything, in addition to the concerns you have expressed about how you would be dealt with by the advisory council. There are some other factors that have also raised the issue of how the advisory council would function. And as has been noted, I think one of the important things is that body not be made up of regulated professionals so it will be a more impartial body.

But that does not prevent us from certainly urging that this is a matter of importance and should be looked at fairly quickly. One of the questions, and it follows along from Mr Wilson's, in terms of your scope of practice: Is the scope of practice in the United States one that is determined state by state or is there the same scope of practice right throughout the country? And I take it, at least in Oregon, it is more expansive than what currently exists in Ontario?

Mr Warren: It is determined state by state, although there is a fairly consistent pattern throughout the states that have licensing. In answer to Mr Wilson, as well as yourself, we are really looking for maintenance of a scope of practice that is already in the law—we do not want a shrinking of that scope of practice—plus the insurance of a few things such as laboratory diagnosis—

Mr Beer: You want to insure what you concurrently do under the Drugless Practitioners Act—

Mr Warren: Exactly.

Mr Beer: —but you also want the diagnostic element that you mentioned before—is that blood testing?

Mr Warren: Right.

The Chair: I know you are aware that if there is any additional information you think might be helpful, you can submit it to the committee through our clerk over the course of our deliberations.

JENNY THOMAS

The Chair: I would like now to call Jenny Thomas. Welcome to the standing committee on social development. You have 10 minutes for your presentation. Just begin now, and also leave a few minutes for questions; we would appreciate that.

Ms Thomas: My name is Jenny Thomas. I am a dental hygienist practising here in Ottawa. I have been practising for the last 20 years in both private practice and specialty practice for a periodontist, which is for treatment of gum disease. I have worked in public health and until recently worked at the outpatients' clinic here at the Ottawa Civic Hospital, where we treat medically-compromised patients.

I should like to introduce two escorts of mine, Doreen Slingerland, who is a registered nurse and has worked with me on projects in nursing homes, and Russell Cecchini, who is one of my clients and is a consumer of dental hygiene.

I have taken the opportunity of meeting with you this morning because as a dental hygienist practising in the field and in continuing dental education, I have two professional concerns, both of which may be affected by the new health legislation. I am giving this presentation for myself. It is not a representation of my official organization and it is not a referenced work.

My two concerns are basically the following. One is the treatment for periodontal disease or gum disease in Bill 43, subsections 27(1) and 27(2), which is the delegation of controlled acts. The group that this affects primarily is the general population. It is the patients of private practitioners—that is yourselves, ladies and gentlemen, and members of the audience here and the population at large. My second concern is access to dental treatment by certain population groups such as the homebound, residents of collective living

centres, refugees and the working poor. This will be found in legislative writing of Bill 47, section 4, for authorized acts.

Let me first turn to my first concern, the treatment of periodontal or gum disease. The causes of periodontal disease are many but the prevention and early treatment of this condition is considered to be best accomplished by assessment, treatment planning, treatment by thorough, meticulous periodontal scaling and the use of antimicrobial substances, and then an evaluation and follow-up. Apart from the periodontist, who is a specialist, the dental hygienist continues to be the most thoroughly trained and accomplished dental professional in these areas, particularly with respect to the treatment or the scaling.

Although there are some geographic variations in demand, there is currently a potentially explosive situation arising in the area of dental human resources. Some dental practitioners are not employing dental hygienists, and the dental profession is pushing for intra-oral duties for dental assistants, including the polishing of teeth. These duties resemble those of dental hygienists but are totally inadequate for the treatment of periodontal disease. These duties should not be used as substitute services for periodontal scaling, and neither should the non-regulated personnel doing them be delegated periodontal scaling or the controlled act of a dental hygienist.

0940

I was interested to see on the inside cover of the pamphlet this morning that the consumer's view of health care was an expectation that the person who provides you with care is qualified. I therefore feel it is important that subsections 27(1) and 27(2) pertaining to delegation must be revised to ensure that under no circumstances should other non-regulated, ie, non-qualified, dental team members, be allowed to be delegated duties that may result in gross mistreatment of gum disease, thus rendering harm to the public.

My second point is access to dental treatment by certain population groups. The supervision of dental hygienists has a long and involved history, and I am sure that you are familiar with it. I have therefore made the assumption that you are cognizant with both how the supervisory clause has been interpreted in the past and that direct supervision requires the presence of a dentist in the office during treatment activities. The implications of this are threefold for collective living centres, community health centres, and the people whom they serve.

First of all, the cost increases, because it becomes necessary to provide two operatories and to pay a dentist. Second, staffing with full-time dentists in these situations is very rare, so the use of the physical space is very inefficient. And, third, if one operatory only is provided, it means that the dentist is the only professional who can practise in that operatory.

I am concerned because over the past eight years I have been dentally treating people who are chronically ill, elderly, and otherwise medically compromised. These people are the most difficult people to treat, both in terms of patient management—for example, keeping them in the chair if they have Alzheimer's disease and like to wander around, and helping them to keep their mouth open—and in terms of physically accessing at least adequate equipment.

Taking them to a dental operatory often requires personal escorts, special transportation arrangements, ambulance service and accessible buildings. If dental hygienists were able to practise in the residences, or within community health centres, either indirectly or unsupervised, access to dental treatment would be much more readily available both physically and financially. And of course the referral system to a dentist would always be available.

I have already introduced you to my escorts today, both of whom have personal experiences with regard to accessing dental treatment. Doreen is a registered nurse and knows only too well the very great need for hygiene services within nursing homes and similar collective living centres. Russell is a consumer. In brief, it took us about 20 appointments to complete what would normally have been done in four or five. The point here is that dental hygienists should be employed in salaried positions within community health centres so that the services rendered to these people are not tied to fees for service, government insurance codes, or business deadlines. Allowing dental hygienists to work at arm's length with global budgets within collective living centres and community health centres would enable that to occur.

The current inclusion of the phrase "on the order of a member of the Royal College of Dental Surgeons of Ontario" could lead to restrictive interpretation that might prevent dental hygienists from providing necessary and less expensive treatments to these people. In my opinion, it should either be removed or the definition of arm's-length supervision well provided for.

I should like to open up the presentation to you for any questions.

Mr Owens: In terms of bringing your service into group homes, nursing homes and things like that, how would you as a hygienist deal with issues around patients who require prophylactic antibiotics to prevent endocarditis and some of the other problems, if we take your concerns and put them into legislation? Would you work with the registered nurse, or would you have that medically compromised person dealt with by a dentist?

Ms Thomas: I do not ever foresee a dental hygienist working isolated in one of these collective living centres or community health centres. I see the system set up so that dentists are there when they are needed. I see a dentist's services required in part of the diagnostic services at the beginning, so that the patient would have been diagnosed and looked at by a dentist, and a dental hygienist can carry out the services that may have been suggested as being applicable. At that time, medication such as prophylactic antibiotics can have been prescribed and the medical personnel on staff in the nursing home can prescribe them and give them.

Mr Beer: Following up on that question, because certainly under long-term care we are going to see the need for more and more of these services in other settings outside of dentists' office and the like, presently when you are providing the service you provide, in practice how does that work when you go into some of these other centres? Do you have to bring everybody into the dentist's office,

r do you have arrangements with dentists with whom you work to do certain things?

Ms Thomas: Currently here in Ottawa we are very lucky, because I work out of the outpatients' clinic of the Ottawa Civic Hospital where we have special arrangements made. In most of the cities and towns in Ontario that does not occur, so basically these people do not receive treatment.

Mr Beer: Those special arrangements, is that in the form of a written special arrangement? If you are going out to treat patients, how is it you are allowed to do that?

Ms Thomas: Even here in Ottawa I cannot at the moment do that without the dentist being on the premises. I am not doing it at the moment. But this is where I see the need arise, because I could then go out to nursing homes if the case arises, which it does. We see the need all the time, but at the moment I cannot do that. I can only do it when people come to me. I have had access to very inadequate portable equipment where the dentist and myself have gone out, but it has been a very efficient use of time, facilities and resources.

The Chair: The committee appreciates your coming today. We appreciate your presentation. Thank you very much. I know that if there is any additional information you feel might be helpful you will submit it to the clerk in writing. Thank you all for coming.

950

JACK GRYFE

The Chair: I call John Gryfe. Welcome. Please begin your verbal presentation now and, if you would, leave a few minutes at the end in case any of the committee members have a question.

Dr Gryfe: My name is John Gryfe. Actually, I prefer to be known by Jack. I am an oral and maxillofacial surgeon. I practise in the city of Toronto. For those who may not know, an oral and maxillofacial surgeon is a professional with a dental degree and then formal surgical training, which may vary but encompasses a minimum of three years, and may have as much as five years, post-dental education. I practise in the city of Toronto. I am also the chairman of the Canadian Dental Association's committee on community and institutional dentistry, and one of the areas we have been very interested in has to do with the technology in dentistry, including the uses of energy.

The Chair: Are you here today as an individual?

Dr Gryfe: I am here today as a private individual.

The Chair: In that case you have 10 minutes for your presentation.

Dr Gryfe: Madam Chairman, ladies and gentlemen, I come before you today as a concerned dentist. In the short time allotted to me I hope to impress upon you the dangers of certain energy modalities currently in use in dentistry when they are handled by inappropriate hands. The proposed health acts legislation, while recognizing this, fails to understand that dentists are trained to use this technology properly. Unfortunately, the proposed legislation provides medicine with the exclusive authority to apply and order the application of these forms of energy.

Specifically I will be reviewing possible hazards in the clinical application of laser technology, other visible light energy, and electrical energy. Yet these are used successfully and safely by the dental profession today.

Electrical energy has been used in the healing arts for almost as long as the modality has been known to man. Electrocoagulation is a well-accepted method for surgical management of certain soft tissue problems. The effectiveness of this treatment is also the likely basis for peril. The hotter the instrument's tip and the longer the tip is applied to the tissue site, the greater depth and extent of tissue destruction. Because the gum tissue covering the bone of both the upper and lower jaws is quite thin, the possible destruction of not only the soft tissue being treated but also of the underlying bone is a real consideration. This is equally true of the fibres that support the teeth in their sockets.

More recently, electricity has re-emerged as a means of therapeutic or pain-decreasing management. In 1987 the American Dental Association issued a status report on TENS, transcutaneous electric nerve stimulation, noting that "among factors influencing TENS performance are training, proper usage and patient selection involving psychological screening." HFNM, high-frequency neural modulation, a recent advance, uses the same techniques as TENS, only with higher electrical current and increased frequencies. The current edition of the Journal of the Canadian Dental Association contains an article on electronic dental anaesthesia, yet another modification of the same technology.

Such potentially harmful forms of energy are commonly used by dentists throughout Canada.

During the last decade, a group of restorative dental materials has evolved that requires exposure to high-intensity white light in order that these substances be cured completely. The light is applied by direct exposure from a fibre optic beam in a hand-held source. Different materials require different exposure times. Failure to cure these materials properly will make them ineffective in preventing further tooth injury. While this light may appear to be harmless, the manufacturer's instructions direct that both the dentist and the patient wear specially tinted glasses to prevent the possibility of eye damage. Because of the effectiveness of these materials, it is likely that their use will become even more widespread in future years.

Perhaps the most exciting energy source is the use of lasers. Laser, an acronym for light amplification by stimulated emission of radiation, is recognized as having the potential to make a significant impact on the practice of dentistry in hard and soft tissue applications.

Three different wavelength groups—ultraviolet, visible light and infrared—produce a wide spectrum of energy beams. These energy beams are converted into heat energy which, when directed at any tissue, begin to increase that tissue's temperature. Depending on the temperature achieved, the target tissue may be coagulated, cut or vaporized. The amount of heat produced is controlled by the laser's power, the laser's wavelength and the duration of exposure. The effectiveness of this energy is also a product of its absorption into a tissue and the extent of scatter of the energy within that tissue. Different tissues have different percentages of water and organic material, each of which

can significantly affect the amount of energy penetration and scatter.

At present, lasers are used to vaporize dental decay within the tooth structure, desensitize teeth to certain pain-inducing phenomena, perform certain soft tissue surgery, and sterilize and vaporize necrotic tissue in a tooth's nerve canal during root canal therapy. A different group of lasers are being studied for their effectiveness in controlling post-surgical discomfort.

Knowledge and professional skill is critical to the effective use of such forms of energy.

The most commonly used lasers in dentistry at present are created using either carbon dioxide gas—the CO₂ laser—or neodymium yttrium aluminum garnet crystal—the Nd:YAG laser—as the laser medium. These two lasers, both described as being hard lasers, have totally different capabilities. The CO₂ laser is a surgical tool which rapidly develops large amounts of heat energy, whereas the Nd:YAG is not capable in its present state of creating a great deal of thermal damage unless it is misused. When using either laser system, however, both the patient and the dentist must wear specific eye protection to prevent optic tissue damage. The patient having CO₂ laser treatment is expected to have his or her eyes protected by the placement of wet gauze sponges over the eyes, followed by the positioning of clear safety glasses over the gauze sponges prior to the onset of laser use.

Energy-producing technology has become an integral part of dental treatment. The techniques required to use these modalities demand a thorough understanding of the physiologic, pathologic, anatomic, chemical and physical implications of their application to prevent a wide variety of misadventures and complications. All of these basic science disciplines are included in the formal education of a dental student.

It is my belief that neither the omnibus bill nor the dentistry bill in their present form properly ensure that these technologies will continue to be available in the dental office. I agree with the review that the ordering and application of these energy technologies should be controlled by a specific act. Further, I would suggest that this controlled activity must be extended to the Dentistry Act. Just talking off the prepared text for a second, I would suggest that what is in subsection 26(7) of the omnibus bill should be reproduced in the dentistry bill directly. Dentists are properly prepared to manage this treatment modality. Under the RHPA we require the authority to continue to use such technology in the treatment of our patients. Thank you for your attention.

Mr J. Wilson: Thank you, Dr Gryfe. I expect the Ontario Dental Association appeared before the review committee on many occasions over the years. Do you have any idea why dentists were not given a controlled act pertaining to energy?

Dr Gryfe: No, I do not. I really have no idea. I did not write the legislation.

Mr J. Wilson: Neither did we.

Dr Gryfe: I only had the opportunity to read it.

Mr Owens: Should we extend this controlled act to your profession, what would be the benefit to the public by having this act within your scope?

Dr Gryfe: My concern is that by not having this as part of the Dentistry Act directly, we are going to lose the ability to use technology which is proven in the health care of our patients at the present time. This is what my fear is.

The Chair: We have a request from the parliamentary assistant to clarify.

Mr Wessenger: I understand the whole matter of energy use is to be allowed under the regulations, and I will ask ministry staff to indicate the reason for that.

Ms Bohnen: I think the issue for the ministry is just really which legislative mechanism is most appropriate. There is absolutely no intention on the part of the government to prevent dentists from using forms of energy which they use in their practice. It is just a question of where within the legislation the authority is best placed.

Dr Gryfe: May I comment on that? Totally acknowledging my glaring deficiencies in not being legally trained, it seems that if the subsection that I referred to is not reproduced directly in the Dentistry Act, then either we are possibly excluded or I suppose the alternative is that anybody else whom the act currently covers in any of the appendages to the umbrella of Bill 43 could theoretically use the same energy. I do not believe that some of these disciplines have the proper training to do so.

Ms Bohnen: Until a regulation is made under the Regulated Health Professions Act specifying hazardous forms of energy or their applications, and further specifying which professional groups may use those forms of energy, the controlled act really has no meaning. It will be through the regulation-making process that, first of all, the hazardous forms are identified and protected and then allocated to the appropriate professions.

Dr Gryfe: Does the paragraph specifically reappear in the medical bill?

Ms Bohnen: It does, for the reason that—according to any view of what forms of energy will be listed, for example the first one that comes to everyone's mind is ECT, electroconvulsive therapy—physicians will be utilizing it.

The Chair: I want to thank you for your presentation before the committee today. If at any time you wish to communicate further with the committee, please feel free to do so in writing through our clerk. We appreciate your appearance today.

1000

ASSOCIATION OF CONCERNED CITIZENS FOR PREVENTIVE MEDICINE

The Chair: I call next the Association of Concerned Citizens for Preventive Medicine. Please come forward and introduce yourselves. You have 20 minutes for your presentation. We would ask you to leave a few minutes at the end for questions.

Mr Dugas: Thank you, Madam Chairman. My name is Ron Dugas and I am the president of the Association of Concerned Citizens for Preventive Medicine, a non-profit,

national consumer organization which is dedicated to the development of preventive health care in Canada. It is incorporated under a federal charter and has a membership of 9,500 members across Canada.

The ACCPM has been associated with the process leading up to this proposed legislation since its inception many years and several governments ago. Because it has reservations on some points, the ACCPM gives a guarded welcome to the proposed legislation. The legislation makes a real effort to ensure that self-governance by professions will be guided by true attention to the public interest. We recognize that effort and appreciate it.

The new law intends to increase public participation in the councils of the colleges. We also welcome this idea. However, we do find the procedures and rules too complex. To deal with this, we urge a simplification of the procedural rules set out in the health professions procedural code without diminishing the efficiency and fairness of self-governance. The system set out in the procedural code and the individual professional acts fails to provide for an essential committee—one to promote and provide continuing professional education.

We welcome the fact that the "monstrous harm" or "potential for harm" clause has been omitted from the legislation before you, along with the draconian penalties proposed by the Health Professions Legislation Review committee. We wish to advise the committee that there are interests which wish to revive some form of harm clause, or whatever reasons. Our concern is that the committee be alerted to any attempt by any person or any organization to introduce such a draconian, irrational and unfair clause again. The ACCPM is firmly opposed to the introduction of any such clause.

As has been demonstrated by the attempts made previously, the only result of such a clause is unjustified restriction of normal constitutional freedoms. The safeguards in the Criminal Code of Canada and under the proposed controlled acts are quite sufficient to provide the necessary remedies and protection. The whole clause offended against common sense and fair play. It was apparent that it was intended to intimidate any person who was not regulated.

We object to the designation of diagnosis as a controlled act and consider it should be struck out. The language has been changed to avoid the term "diagnosis," but this is what is meant and intended. In our view, this clause lacks the rationality found in the remainder of the legislation.

First, it prevents an unauthorized person from stating to the patient what he or she believes to be the problem, and the causes of the person's health difficulty. This is, as far as we are concerned, an infringement of free speech and communication.

Second, it means that a patient is expected to accept treatment from someone who has to explain what treatment they intend to apply or advise but is not permitted to explain the whys and the wherefores.

Third, there is only one rational explanation for this clause, that is, it is intended to make impossible the practice of any form of physical, nutritional or psychological therapy by any person who is not a member of a regulated profession. That was an intent also of the original harm clause and the

original diagnosis clause. It continues to be the reason for the diagnosis clause under review here.

Fourth, this clause will make impossible—except through exemption by regulation, for which there is no guarantee—the practice of natural healers, psychotherapists, social workers, pastoral counsellors, parole officers and crisis counsellors. With this clause included, the act would throw thousands of unregulated health care workers into legal jeopardy.

Fifth, if you leave it to the courts to settle what the clause means, you will be putting all unregulated and many regulated workers in legal jeopardy.

An article which appeared in the *Globe and Mail* of August 8, 1991, under the editorial section supports the practice of traditional medicine and a regulatory regime which does not suppress it. This is what the *Globe* had to say in part:

"The practice of traditional forms of medicine is growing rapidly in Canada. Many Canadians, dissatisfied with the conventional system, are turning to these healers, and practices new to Canada have been brought here by the recent influx of migrants of non-European origin. It is based on centuries of human experience.

"While many Canadians might not want to seek the advice of natural healers, their reluctance should not translate into a regulatory regime that denies others the opportunity. In both Europe and Asia, conventional medicine and traditional medicine live alongside each other and work together for the health of the people. They need to learn to do so better in Canada."

This clause is an offence against common sense and fair play. It can only be supported on the basis of trying to maintain a monopoly situation. It cannot be justified and should be deleted.

The naturopathic profession has been omitted from the legislation although it has been a regulated profession since 1925. However, the wrong which has been done to the naturopathic profession has been recognized. The Ministry of Health is proposing to include a naturopathy act after this legislation has gone into effect. Meanwhile, the present legislation allows for the continuation of the *Drugless Practitioners Act* in such a way that naturopaths will continue to be regulated. However, as we point out in our submission, the presence of the diagnosis clause and the exclusion of the naturopathic profession from the schedule of regulated professions would effectively bar this profession from practice.

We feel that in order to deal with this situation a naturopathic act should be added to the legislative package with consequent amendments. The ACCPM is appreciative of the proposal made by the former Health minister, Ms Gigantes, that acupuncture will also be exempted from the controlled act. If acupuncture is not to be a regulated profession, as we believe it should be, then it is fair and right that provision should be made to exempt acupuncture from the prohibition of using the controlled acts which it needs to employ in order to be able to continue its practice.

Unfortunately, the promise made by the former Minister of Health, although sensible and well-intentioned, is general in its terms. It does not say what licensed acts, nor does it

specify when the exemption will be implemented. We recommend that acupuncture be added to the list of health professions in schedule 1.

Madam Chairman and committee members, these recommendations from the ACCPM are intended to support such major factors as justice, fairness and non-discrimination. Thank you very much.

1010

Ms Haeck: Thank you very much for a very informative presentation. We have had a few presenters with a, shall we say, strictly consumer orientation rather than a professional one. I will have to admit my own bias in this: I would like to see broader consumer education.

How would you approach that particular issue of informing the general public about the variety of specialties? You mention naturopathy and acupuncture as two that are of interest to you, as well as the concern about the diagnosis clause. How would you, in the process of preventive medicine and all the things that you stand for, make the public much more aware of those kinds of concerns?

Mr Dugas: We honestly believe this is a dual role. Not only the consumer organizations but the government itself have to play a leading role in informing the public as to what the different disciplines are, the qualification, competency of groups, and so on. It is very, very important for the government—and I think it will be with this advisory council which will be formed later on after this becomes law—to work co-operatively with consumer groups to relay this type of information to the public.

Ms Haeck: With the diagnosis clause that you obviously feel quite strongly about in its current format, do you not believe that it is really going to protect the unregulated professions as well as the public?

Mr Dugas: I think it is a foregone conclusion. I am sure you know that many groups have addressed the committee and have indicated their gravest concern about this particular clause. As we have explained in our submission, how can we support, as an example, unregulated practitioners and also regulated practitioners, if they cannot actually give a diagnosis to a patient? We feel this is an impossible task.

As we have indicated also in the submission—and this is one part I think that the committee members have to fully understand—if I as a consumer am prepared to pay out of my own pocket to see a natural healer, at no cost to the taxpayer, why should I have restrictions in the law which will not permit me to get a diagnosis from someone I feel is competent, if I feel I do not want to be treated by conventional means, be it drugs or surgery, as an example? We feel this is a very important factor and should have an impact on this legislation.

Mr Beer: The two intentions, as I understand the legislation, are: one, to protect the public, and second, to develop greater access. Clearly, in the areas that you are discussing, for many people there are many new practices that are, if you like, pushing the envelope, changing the way we look at health care and health services. I wonder if you might comment on the advisory council and its proposed role once this legislation, with or without amendments, goes

forward, in terms of dealing with perhaps what we call newer professions that will come along wanting to be self-regulated. What are the key things that you would want to see in the way that advisory council functions? Perhaps you could give us some comments on that.

Mr Dugas: We have had a good look at the area of the advisory council, and I must say that we are pleased with the manner in which this has been struck. With many of these new disciplines that might be up for regulation, very definitely we feel the safeguards are there. I cannot add too much, because I personally, as president of the organization, and our organization are quite pleased with the proposal under advisory council.

But I would like to make one more point, and I think it is important. Often we hear about charlatans, and I think it is good to raise this, because as a consumer I feel it is important for people to understand where we stand and where we are coming from. Many times when we are speaking of a traditional medicine, people think immediately of charlatans. Let me give you an example, and this is where we can have a professional group, be it the medical doctors or anybody else, have a complete monopoly on a system. Let me give you an area that you should be having a good look at, because you can have charlatans among medical doctors the same as you can have in traditional medicine.

There is one controlled act which really concerns us, and that is the controlled act 4, which has to do with the moving of the joints of the spine. Let me tell you, if you were, as an example, to see the background and the education of a chiropractor, where the general thrust of what he learns has to do with the manipulation of the joints, he does this continually. He becomes a specialist in it. The way this is now drafted, any doctor, a general practitioner, as an example, can actually work the spine on a patient. Maybe that general practitioner, as an intern, has taken a course of maybe a few hours' in manipulation of the spine. I can understand if you are talking about a specialist who deals in surgery about back problems. He certainly has all the competency that you would want. But I would much rather go to a chiropractor than go to a general practitioner when it comes to my spine.

So I say, is this not a bit charlatans when you talk about—it is not the fault of the medical people. But I am saying, let's have a good look at the law. It is not because a group is professional that they have the competency in dealing with the health care situation.

The Chair: Question, Mr Wilson, one minute.

Mr J. Wilson: Just going back to the diagnosis clause for a second, you mentioned, as a number of groups have, that it should be scrapped. But do you have any suggestions for the committee on what might replace it, given that we have all read in the papers and as members we have all had the calls to our offices by people who have visited so-called quacks? You are right, when people pay out of their own pocket they expect a level of competency. But fortunately the legislation is being introduced to try and get rid of the quacks. So what would replace that section?

Mr Dugas: I am sure you have met with Professor Evans, and we have worked with him all along. There is

one particular clause in there which maybe we as consumers feel we could live with, and that is the competency clause. But this would be difficult again. The only thing we would worry about is if you went before the courts and had a judge, or he had a committee, completely versed in conventional medicine, and not knowing anything about traditional medicine, maybe then they would not get a fair shake due to the fact that the judge or the courts do not fully understand what this other medicine is all about. But maybe there is something that could be worked from that competency clause with regard to the different disciplines.

The Chair: Thank you very much for your presentation.

020

MATTHEW YEAGER

The Chair: I call Matthew Yeager. Welcome. You have 10 minutes for your presentation and we would ask you to leave a few minutes at the end for questions.

Mr Yeager: Thank you. My interest in the legislation, Bill 43, is primarily with respect to the disciplinary systems currently in operation among the five health professions regulated by the Health Disciplines Act and the improved system that is proposed in the bill presently before this committee. My motivation is that of a researcher long fascinated by the area of white-collar deviance, and therefore I come to this area with a perspective markedly different from most of the witnesses you have heard.

To date, I have had an opportunity to conduct a preliminary inquiry into the disciplinary systems of four of the largest professional colleges, those being the College of Physicians and Surgeons of Ontario, the Royal College of Dental Surgeons of Ontario, the College of Nurses of Ontario and the Ontario College of Pharmacists. Together these four colleges, as you know, represent about 180,000 licensed practitioners in this province.

Under the existing act, each college is required to establish a separate registration and discipline committee, and the act gives these committees the legal authority to hold formalized hearings with the legal power to revoke or suspend a practitioner's license.

While the public may assume that these two committees handle the majority of misconduct/incompetence cases, such is not the case, at least by my preliminary inquiry. For example, of the 95 decisions issued by the complaints committee for the dental college from April to October 1990, only 6% were referred to the discipline committee. Apparently even fewer cases are referred by the executive committee to the discipline committee, which initiates its own investigations into some of the more serious rule violations, such as drug trafficking, misuse of prescriptions, drug addiction and sexual abuse of patients and/or staff. With respect to the College of Nurses of Ontario, only 23 cases, that is, 4%, were referred to the discipline committee. That is out of the complaint committee. An additional number of cases were referred to the registration committee.

Because the formal power to revoke a licence is vested in only two committees, all of the professional colleges have tended to keep disciplinary matters away from these two bodies. Indeed, my preliminary studies have found that potential disciplinary cases can be found across a

number of different committees in each of the colleges. I say potential because, to my knowledge, no governmental body, including the Ministry of Health, which has oversight responsibility, has conducted an audit of any of the complaints/investigations being processed by any of the professional colleges.

The situation is compounded by the fact that a number of potential reporting sources for assessing misconduct or incompetence are entirely separate and unconnected to the professional colleges. This is true for the Ontario health professionals assistance program, which is a private program that receives moneys from the colleges to only make treatment referrals and conducts no follow-up, and is also true for the various malpractice insurance claim programs where litigation is commenced against a health professional. It is also true, interestingly enough, with respect to the quality assurance program of the College of Physicians and Surgeons, which is kind of a random survey each year of about 250 physicians, where they go in and do an audit of their office.

Indeed, it is difficult to fully understand the scope of professional discipline or to analyse trends from year to year, because none of the colleges has a computerized database for discipline cases that would permit a comprehensive statistical study.

With the above in mind, it is incomprehensible, at least in my opinion, that the proposed legislation would continue to balkanize discipline matters among a host of committees, those being executive, registration, complaints, fitness to practise, quality assurance and discipline. I strongly recommend to the committee that only one entity be created within each college to conduct investigations, receive complaints and dispose of those complaints. This means that the activities of the complaints, discipline and fitness to practice committees should be combined and that all special investigations be managed by this new unit, so that the entire disciplinary process is housed together and therefore better susceptible to external review.

As you well know, the minister has the authority to audit any of the five colleges under the existing Health Disciplines Act, a power which is discretionary, not mandatory. In fact, I was amazed to learn that while the Health Professions Legislation Review conducted a survey of other disciplinary systems in the US and foreign countries, and indeed other provinces, no statistical research was conducted of any of the existing colleges in Ontario. In fact, I am unaware of any research agenda by the Ministry of Health in this area, which in my opinion is the greatest single indictment of government-delegated self-regulation of the health professions. I would therefore recommend that Bill 43 mandate that the minister audit the disciplinary system of each college every several years.

The remainder of my observations are somewhat technical, and I will not bore you with going over them so that perhaps you can ask me a question or two.

Mr Jackson: Professor Yeager, thank you for a very stimulating brief set out very succinctly. I have a dozen questions and I am only going to get one or two on.

Perhaps I can ask staff on your behalf, with respect to recommendation 1, the point you raise of combining the

various groups into one body, is it possible for our legislation that we are currently working with, to reach into this area, or are the regulations governing the point raised in recommendation 1 by Professor Yeager found in other legislation or within the regulatory frameworks for the separate colleges?

Mr Wessenger: I would just like to comment with respect to recommendation 1. I think there is a major problem with combining the whole disciplinary procedure with the complaints procedure, in that if you are trying to have the principles of natural justice prevail, it is somewhat unfair to have the prosecution and the judge all on one body. I think it is very important to have a separate body hear the complaints in order that fairness is given to all concerned.

Mr Yeager: The problem, Mr Wessenger, that you have with that theory is that what you have done by creating that structure is you have a very logical behaviour occurring among all the professional colleges. They are doing everything they can to keep the disciplinary cases out of the registration and disciplinary committees.

They have the formal power to revoke and suspend. While you may think in theory that it is good to have a separate complaints unit to investigate complaints, what happens is that the natural tendency is for these bodies—and of course, they have the power to affect the livelihood of their members—to keep those cases away from the powerful committees that can perhaps do some damage to their profession.

I think that is really the wrong approach. I think that for the purpose of conducting external review and studies and to look at how they are disciplining, and here we are talking about rates of revocation, rates of suspension, recidivism—we know nothing about the recidivism of health professionals in this province. I was not able to locate any studies that could tell you over a period of 10 years which physicians or dentists or pharmacists had two, three, four, five, six complaints against them. It does not exist right now. I think I would take a minority point of view and suggest that perhaps the committee reconsider the structure, because this behaviour is normal behaviour that is dictated by the structure of how you set up the committees.

Mr Wessenger: I think I would like to also have ministry staff comment. They would like to have an opportunity as well.

Ms Bohnen: I would like to comment, first to answer the initial question that was asked. It is this legislation which provides the structure and the rules for the committees. It is not any other legislation or the regulations.

In terms of fitness to practise, it is important to remember that it is completely different from discipline. It adjudicates cases where it is alleged that a member may be physically or mentally incapacitated. It starts essentially with information coming to the college. Then it goes to a board of inquiry. Usually outside examinations are conducted of the member's capacity. So I do not see that the same factors or influences come to play in dealing with incapacity as in discipline.

The theory of having separate complaints and discipline is to have a much more consumer-friendly complaints

procedure whereby individuals can have easy access to a complaint investigation and it can operate as a kind of screen. I think that many of the colleges and professional associations would certainly dispute the speaker's suggestion that there is an intention in the colleges to keep cases away. I think what might be relevant to that is the fact that of cases reviewed by the Health Disciplines Board brought there by complainants who are not satisfied with the outcome by the complaints committee—I cannot give you a statistic, but I believe only a small proportion result in a recommendation that the case be referred to discipline.

Mr Yeager: Criminologists historically have dealt with the issue of manifest and latent function, manifest being what rhetorically the colleges say they are doing and want to do, and latent meaning what they are really doing. What they are really doing with the vast majority of disciplinary cases is keeping them out of the formal committee structure. I think that is an error you ought to re-examine. You as a ministry official need to re-examine your whole oversight procedure because you have no ongoing research program and you have no ongoing auditing program in terms of looking at the oversight of these colleges and what is going on.

That would be my testimony. I am sure if the committee has some follow-up, I can be contacted.

The Chair: Thank you very much for your presentation. Similarly, if there is additional information that you think would be helpful to the committee, I would encourage you to submit further briefs in writing.

Mr Yeager: I have a report coming out on the pharmacists. I would be happy to forward that.

The Chair: Thank you. The committee will look forward to it.

1030

ONTARIO PSYCHIATRIC SURVIVORS' ALLIANCE OF OTTAWA-CARLETON

The Chair: I would like to call now the Ontario Psychiatric Survivors' Alliance of Ottawa-Carleton. You have 20 minutes for your presentation.

Mr Carne: My name is Bill Carne. I am the chairman of the local branch. This is Cathy Munroe, a member of our local branch.

This is by way of background. We are a group of present and former psychiatric patients who have gotten together for self-support as well as to try to improve the quality of mental health care, this being one example. As some public relations here perhaps, we prefer the word "survivor" to "consumer," "client," "user" or that sort of thing, as they indicate a very weak and dependent position. We have overcome the crisis. We have come through it with our skill, our knowledge, our wisdom. It shows something much stronger.

We have used the mental health system and we know where it does not work. The presentation I am making here will be covering basically Bill 55, which is our area of experience and interest, the profession of medicine and particularly psychiatry. Our comments may prove of value to other professions. I have four points to cover.

We really would like the principle of self-governance to be examined and perhaps replaced. There needs to be a more effective feedback mechanism so that the profession can be allowed to improve in the quality it presently gives.

Second, the complaint process must allow an ordinary citizen to be able to place a complaint with a reasonable expectation it will be acted upon. The complainant must not be made to go through undue hardship for a valid complaint. As the present system exists, the doctor seems to have great advantages over the complainant.

While I was looking at this early this morning, the present system seems to be grossly flawed, at least in my knowledge of what exists. It seems to require the injured party and not the college to be responsible for detecting, reporting and, in a sense, prosecuting professional misconduct and incompetence.

Third, the percentage of doctors on the committees of the College of Physicians and Surgeons of Ontario should be less than it is at present. We would like a lot of other people to be on there, perhaps even a majority, so that other viewpoints can be seen looking at the health situation. This would allow for a sort of a cross-culturalization of all these perspectives and maybe improvement of all of them by this mixing.

Fourth, there is a need for standards and guidelines of practice. This is quite obvious. How can high standards of health care be expected to be maintained if there are no standards by which to judge if what you are doing is good or bad?

In a little more detail, self-governance seems to be nice for the members of the governing body, but it does not seem to be that effective. The report from the Task Force on Sexual Abuse of Patients indicated there was a lot more abuse than was actually going through the college. In the States the psychiatrists, through self-reporting, said between 7% and 15% of them had sex with their patients. This is clearly professional misconduct, but it is not coming through the college, and so what exists now needs to be changed and improved.

Most of my friends are not psychiatric patients, but they have extreme complaints against the specialists' arrogance and insensitivity. For us the situation is even worse, because when we start complaining about something, that just is seen by the psychiatrist as proof of our diagnosis, that we have another one. Somehow a better system of feedback and supervision is necessary, supervision so that their decisions can be looked at and re-examined and feedback just to make sure they are staying on course. The example I like giving is try driving with your eyes shut. If you have no feedback, you do not get very far.

The next point is the complaint process. Very valid and serious complaints against doctors are not filed with the College of Physicians and Surgeons because people correctly realize that it is not worth it. It is a very unequal contest between the charged doctor and the person making the complaint. As an example, the person who is complaining is an outsider to the field of medicine, its jargon, terminology and attitudes. A doctor has the expertise and money of the Canadian medical protective association on his side, whereas a complainant, I believe, has to use his own money.

Most of the people on the committee are colleagues of the doctor. These doctors have been taught to approach a situation in a very narrow and prescribed manner. In many cases, better alternatives do exist. There is also a great deal of trauma involved, especially if a loved one or yourself has gone through some distress because of your treatment.

Again, to me there seems to be a gross flaw in this system. This is not a case of civil court. It is a case of trying to prove the quality of the profession and I see no reason why the complainant should spend his time and money, as well as endure distress over a long period of time, to try to improve the professional standing of the college. To me, this is really the duty of the College of Physicians and Surgeons, not the complainant.

We would also like to make it more user-friendly to the injured party. As I was saying before, the way it is presently written, the implicit assumption is that it is the duty of the injured party to take on the responsibility of the college and that seems to us to be absolutely nonsense. Just as a suggestion, and there will be some extra cost in doing this, but I think if more effective feedback of these doctors were done, in the long run their competence would improve and that would reduce medical costs. It would also reduce injury, pain and suffering and lack of productivity for those who have suffered injury because of the doctors.

Doctors are taught in medical schools to approach a problem in a strict and limited manner. We would like to have social workers, psychologists and laypeople on there with their own different perspectives of mental health. By having this intermixture, you get a broader view of what has taken place and I think the professionals themselves, all of them, would increase in their competence.

1040

Finally, setting guidelines and standards of practice: I understand the College of Physicians and Surgeons is considering that, but I think this body should put some sort of time limit in there, because it may take an awfully long time. I believe the insurance companies in the States are insisting that doctors set guidelines in an attempt to save money. I can perhaps see the same thing happening here in Ontario. If the guidelines exist, maybe the Ministry of Health can save money.

As one last point that is not in here, this group at 10 o'clock, the Association of Concerned Citizens for Preventive Medicine—that is one thing our group is trying to do, to have alternatives where they presently exist. I will give you one example. One of our members spent a year in the hospital with a diagnosis of schizophrenia. He spent many years taking the so-called schizophrenic medication and now his hands shake. On his own, he discovered oil of evening primrose. His so-called schizophrenia disappeared. His body did not produce—

I am quite sure there are lots of other cases out there where a diagnosis of mental illness is actually something due to a physiological problem which perhaps these people could resolve if they were not limited by their apparent concerns with this legislation you have. I think that is my 10 minutes I was supposed to speak for.

The Chair: Thank you very much for the thoughtful presentation.

Mr Owens: I think psychiatric patients are probably the most visible scars we have on our society of what can possibly go wrong. You mentioned schizophrenic patients and the effects of Haloperidol.

In terms of the kinds of regulations that you would be looking for the college to write, how could we make that complaints procedure accessible? Would you want signs posted in doctors' offices explaining the procedure and who to get in touch with or where to get in touch with people? What kind of recommendations would you make with respect to that?

Mr Carne: I think that is very hard to do, because every case is quite different. I myself was trying to make a complaint against one of my doctors. I wrote to the College of Physicians and Surgeons about three years ago, asking what standards exist for psychiatry so I could compare what happened to me with the standards and decide whether it was worth while going through the process, but because there were no standards, I just felt it was worthless. I think having some standards of practice within two and four years—as I recommend, guidelines for two years, standards for four years—is quite important.

As I was mentioning earlier, it is not a matter that we come there, if you are assaulted by somebody else, the court system takes over and does all the work for you, does the legwork, does the investigation, does the prosecution for you. If you have a complaint against your doctor, it is more like a civil court where you have to lay the charge and you have to prove the charge. Whereas to me, if the College of Physicians and Surgeons, as in our case, is trying to really maintain high-quality standards, it should be doing the prosecution of faulty doctors, not the person who has been injured. Those are two things I can recommend that I can think of.

Ms Munroe: If I can speak to it as well, one of our other concerns is that a great many of us are marginalized and impoverished and oppressed, in a sense, by that system. Whether or not there can be individual notices of process in individual doctors' offices, there should be a system of advocacy and public education in the public hospitals and in the mental health centres and in the community health centres. Perhaps that is another tactic to begin at this point—I do not think it has been attempted before—to look at the Advocacy Act and to look at the human rights issues involved in this issue.

Mr Beer: My question is with respect to your comments around self-regulation. Is it not equally important that the professionals have a specific and direct concern about the issue of standards, the way in which they practise? That, in a sense, is why we want to have these professions self-regulated, in that the protection for the rest of us lies in the participation in the college and the kinds of standards and so on that would be drawn up.

I would be concerned, if I understand the thrust of what you are saying, that you could then be saying to professionals, "You don't really need to be concerned about those, because those are going to be dictated by government." Do

we not need to find a model where we have both involved, but where we make sure the professional is directly involved in the regulation of his or her profession?

Mr Carne: I will make two comments here. One of my degrees is in social work, and we always talk in terms of filters, in the sense that if you are wearing yellow glasses, everything you see is in yellow. Most professionals get so caught up in their own little area of expertise that they do not see the rest of the world. By having a lot of outside people and outside professions, health-related, they are still talking health but with a much broader perspective than any given profession would.

Second, I believe the College of Physicians and Surgeons of Ontario has lawyers around to provide details and technical competence on the law. I quite readily recognize the need for, say, a surgeon or something like this to make presentations about the technical nature of their thing, but there are lots of cases, like in the case of sexual abuse or cutting off the wrong limb, where professionalism is not required. It is very simple.

So I recognize the need for professionals to have input, but I do not think they should have the total majority say, like they presently do. I think it is outweighed about 4 to 1 in most cases.

Mr Hope: With the increase of laypeople actively involved in the committee, in the area of more direct power, would that not then straighten out the problems that we are seeing? We all understand the issue of trying to access complaints or access to human rights; it is such a complex situation, people fall down. But on the inner side—and I have always thought if you wanted to change things, you change them from the inner structure. You referred to the yellow glasses, where everybody sees yellow. Would this not bring the blacks, the whites, the blues, the purples and all the other colours in the place, when we increase the lay members?

Ms Munroe: I think that is what we were recommending. Mr Beer had mentioned making it a more consultative process. That is one of our wishes, that laypersons include people who have gone through some of the same procedures, successfully or not. Lay persons might include lawyers, might include professors of ethics, might include other professionals with their own particular viewpoint.

We recognize among ourselves, as survivors of the psychiatric system, that doctors have a position of power and privilege and they have a very strong interest in maintaining this privilege. They do seem to be threatened on all sides by this wish among the society that things be opened up. I do not think it can be done while they are self-contained and while self-regulation is the only practice. There needs to be more equality.

Mr Hope: Now for the second part of that, and that is why I wanted to put it forward again. The second part of it is, would we be drawing battlegrounds inside the area of the councils? You do not want to create more controversy inside of it; you want to be able to do constructive things. I am just wondering how we would do constructive things if we do that.

Mr Carne: I think that would probably depend upon the individual people you choose. Our particular organization covers all ranges, from people who are totally anti-drugs, anti-psychiatry, to people who are very pro-medical model—whatever the doctor says goes. But there is about 90% in the middle that we all agree on. I would hope you could choose people for your committees who are open to other ideas and prevent this professionalism saying, "I've got the best way and you stop treading on my territory," sort of thing. As long as you have that, you are going to have a mess of a health care system. If you can develop some process—I do not know how, I must admit—whereby you get these people working together to improve and say, "This is your area, this is my area," and on a consensus model work together, it will do much better. How, I do not know. I do not know these people who are up to that.

The Chair: Please feel free to communicate with us in writing if there is additional information that you think might be helpful to us. Thank you.

1050

ANDRÉE DURIEUX-SMITH

The Chair: I call Andrée Durieux-Smith. Welcome to the standing committee on social development. You have 10 minutes for your presentation.

Dr Durieux-Smith: Madam Chair and members of the standing committee, I would like to thank you today for the opportunity of coming to address you.

My name is Andrée Durieux-Smith. I am the director of the department of communication disorders at the Children's Hospital of Eastern Ontario here in Ottawa and an associate professor in otolaryngology in the faculty of medicine at the University of Ottawa. I obtained my PhD in audiology at McGill University in 1974, and my research interests and clinical specialization are in the area of hearing screening of high-risk infants. I am here today as a PhD audiologist and as a member of the Ontario Association of Speech-Language Pathologists and Audiologists to express my concerns about section 30 of Bill 43.

Section 30 of Bill 43 restricts the use of the title "doctor," a variation or abbreviation or an equivalent in another language in the course of providing or offering to provide, in Ontario, health care to individuals," to members of the colleges of chiropractors, optometrists, physicians and surgeons, psychologists and dental surgeons.

As it stands, section 30 of Bill 43 is unjust to both the public and health care professionals. The reasons are as follows:

First, the title "doctor" has historically been used to address individuals trained at the PhD level. Excluding some PhDs from using this title in health care goes against standard academic practice in other provinces and in other countries. Imagine the situation where a PhD with a university affiliation could use the title in an academic setting but would have to change his name tag when he crossed the boundary between university and health care settings. This situation is illogical.

Second, the government's attempts to reduce confusion on the part of patients and the public are certainly commend-

able. If the purpose of section 30 is to reduce confusion, it falls short. In fact, it legislates confusion. How is the public to know which professional with a PhD they may call "doctor" and which professional they may not? Imagine a situation where a child has had an assessment by a team of professionals in a teaching hospital such as the Children's Hospital of Eastern Ontario. This team, for example, includes a paediatrician, an otolaryngology resident, a psychologist and a PhD audiologist. The parents meet with the team to discuss the results of the assessment. They would have to be instructed to use the title "doctor" when addressing the psychologist, but not the audiologist. Would this situation not be confusing? Would it not also give a message to consumers about the worth of different professions with similar training?

Third, the proposed legislation would remove the consumer's right to know the qualifications of his health care providers. Consumers have this right, and only then can they make informed decisions about their own health care. Consumer education is an integral part of health care. To promote ignorance about the different training of health care professionals is retrograde.

There is no reason to suggest that non-physicians who have the title "doctor" would willingly mislead patients into believing that they are physicians or surgeons. The Ontario and Canadian associations of speech-language pathologists and audiologists have codes of ethics which clearly state that members must not misrepresent their training or competence to the public. A truthful representation of our training and competence can only take place if consumers are made aware of our qualifications.

Fourth, the proposed legislation is a disincentive to excellence in health care in Ontario. The PhD degree reflects specialization in a clinical area, as well as research expertise. This allows the PhD to bring a broad range of knowledge to the provision of clinical health care services. PhDs also have the skills to objectively measure the effectiveness of clinical practices and to develop new empirically based techniques that will encourage and allow for a greater degree of accountability. The proposed legislation does not recognize the value of enhanced academic qualifications and would certainly discourage many professionals from obtaining higher academic degrees.

Finally, the proposed legislation reinforces gender biases in the health care system. The professions which will be allowed to use the title "doctor" under section 30 are male-dominated professions, with the exception of psychology, whose membership is approximately 50% female. Those professions that will be precluded include speech-language pathology, audiology, nursing, occupational therapy and physiotherapy, which are all female-dominated professions.

Unchanged, section 30 would support the differential treatment of female- and male-dominated health professions and would send a clear message that the government of Ontario does not support equality in the health care system, but rather gender bias.

Section 39 of the act does state that subject to the approval of the Lieutenant Governor in Council, the minister may make regulations allowing use of the title "doctor." It

seems illogical that doctorates in female-dominated professions would be required to apply for special permission to use their rightful title.

In summary, these five points clearly illustrate the need for the government to review section 30 of Bill 43 and expand the use of the title "doctor" to those health care professions offering doctorate degrees. Thank you.

Ms Haec: Thank you very much, Dr Smith. This is in some respects a personal concern, because I have had, not because of my own health but a member of my family, a few too many trips to Henderson General Hospital in Hamilton in the last few years. As you can probably appreciate, there is a sea of white coats that one does have to come to grips with.

Knowing that the vast majority of patients with whom a health professional comes into contact may not be totally aware of qualifications and all of the various specialties, how do you address the confusion that they may perceive in the title "doctor"?

Dr Durieux-Smith: I have been a director at the children's hospital for 17 years and have dealt with families and their children. I do make it clear when I start off. I say that I have a doctorate degree, that I am not a medical doctor.

I am confident that the title "doctor" reflects my level of education. I think consumers have to be educated that if the title is used, it just means that the person has had extensive training, and that they should not be confused with a physician, a surgeon or whatever. I feel that it is through consumer education that these professions can be recognized and that the consumer can become aware of the different levels of education of their health care providers.

I honestly have never had this problem. I have dealt with families from all the socioeconomic strata. My degree is on my wall, it clearly says PhD, and I just describe what I do and who I am.

I have also been able to bring the dimension of research to my department, which I think ties in with quality of care and certainly has an impact on quality of care.

The Chair: Thank you very much for appearing before the committee today. We appreciate your presentation.
1100

BEREAVED FAMILIES OF ONTARIO, OTTAWA-CARLETON BRANCH

The Chair: I call Bereaved Families of Ontario, Ottawa-Carleton branch. You have 20 minutes for your presentation.

Ms Huckabone: I am Jean Huckabone. I am the executive director with Bereaved Families of Ontario in Ottawa-Carleton. Bereaved Families of Ontario is a self-help organization working with professionals in this province. In 1978, there were five chapters throughout Ontario, and today we have 17, and are continuing to grow.

Essentially, with the help of professionals, we train bereaved persons to facilitate small discussion groups and provide one-to-one support. We help families accept the reality of their loss, rediscover the meaning of life, and live comfortably with memories of their child or loved one.

We also educate the public and the health care profession to become more aware of the special needs of the

bereaved. Additional support is given families through monthly open-support nights, with an additional night for survivors of suicide. We provide education programs, guest speakers, a newsletter, and an overall caring and compassionate support system.

I am here today to make a presentation to this committee regarding the Regulated Health Professions Act, known as Bill 43. Specifically, Bereaved Families of Ontario is concerned with that part of the act known as the diagnosis clause. This clause could, in our opinion, greatly affect the ability of social workers, with whom we work a great deal, to readily provide services to our families who have recently experienced the death of a family member.

As I understand the information that has been brought to my attention, the diagnosis clause under subsection 26(2) would severely limit the ability of social workers to communicate or discuss a medical diagnosis with a patient or a family member.

Usually of course, it is a physician who presents a diagnosis to a family about their loved one. Unfortunately, it is often the situation that the actual interpretation of this medical diagnosis for the family is left to other members of the health care team. Interpretation may involve discussion related to prognosis, lead time until death may occur, the possible ramifications for individual members of the family and the family system, and discussions of levels of interventions and medical options available.

The experience of Bereaved Families of Ontario is that the team member frequently called upon to carry out these tasks is the social worker on the hospital medical team. It is critical, in our experience, that our families have an opportunity, prior to their member's death, to discuss and prepare for the eventuality.

We know clearly that those family members who come to us after experiencing the death of a loved one, and who have not had an opportunity to review carefully the impact of the death, to take part in decisions related to the quality of life and the death experience and come to grips with some of their intense feelings, do not manage as well as those families who had an opportunity to work through and experience these aspects.

There are many scenarios that could be related to the committee to explain the importance of social workers to the families that come to us. A current issue is that of patients with AIDS or who are HIV positive. A case might involve a young mother who has contracted the virus unknowingly from her husband. To further the tragedy, she has passed this HIV-positive trait on to her newborn. It is our hope that, prior to this woman coming to see us for assistance, she has had the opportunity to deal with her intense feelings of anger, guilt, bewilderment and so on with a social worker at the hospital. When she comes to see us, we will carefully monitor her progress with the assistance of our social work consultant while she participates in our self-help group. Should she require further assistance that is beyond the capability of the self-help group, our social work consultant is available to meet with her.

How any of this could take place without discussion of the husband's diagnosis of AIDS and her own and her child's diagnosis as being HIV positive, is impossible to conceive.

The fact that, under the terms of the proposed act, the social work profession is not included as a regulated health profession and that, furthermore, the act calls for fines and imprisonment should a social worker carry out one of the controlled acts, is reason for serious concern. It would be impossible for social workers assisting our families to discuss with them the events leading to the family member's death, their personal feelings of guilt, anger, sadness and heartbreak, and then help them to pick up the pieces of their life once again, without discussing the medical diagnosis.

If there is any possibility that a legal interpretation of this proposed act could put social workers at risk when trying to help our families, they will not be able to assist us or our families adequately.

On behalf of Bereaved Families of Ontario, I am asking this committee to recommend that this diagnosis clause be amended or deleted so that social workers will be able to carry out the function for which they are aptly trained. Failure to do otherwise will clearly hamper their efforts to provide service to the public and quality health care to families already in grief.

I would like to thank the committee for its time, and I would now like to turn it over to my two colleagues.

Mr Giles: I am Bob Giles. I am director of social work at Ottawa Civic Hospital. I am also here as a member of the Ontario Association of Social Work Administrators in Health Facilities.

Ms Tataryo: I am Karen Tataryo and I am director of social work at the Children's Hospital of Eastern Ontario here in Ottawa.

Mr Giles: We will take questions actually. That is what we are available for.

Mr Owens: Thank you. Formerly in my life I was involved in volunteer work with terminally ill patients as well as sitting on a psychosocial committee on the treatment of AIDS patients at the Toronto General Hospital.

My question is, how do you see the discussion of a diagnosis contravening the controlled act of diagnosis? As a social worker or as a volunteer, we are not making that diagnosis, simply discussing the diagnosis of AIDS or whatever the condition may be. I am not quite sure how that contravenes the controlled act.

Mr Giles: The discussions we had around this seemed to revolve around the word "communicating". It is open to very broad interpretation. When we talked with Jean and she was expressing her concerns, this kept coming back; that even though there is a formal diagnosis that only a physician should be portraying for the first instance, it is the continued involvement of that diagnosis that seems to get in the road, identifying diseases or disorders or dysfunctions as cause of symptoms and so on.

That part in the legislation is just so broad and open to interpretation that we would really like to see if we cannot either amend it to firm it up or get rid of it completely so that it leaves social workers, working with families from Bereaved Families, for example, more open and free to deal with the patient's concerns.

Mr Beer: Just one further question on that specifically. I guess what we are wrestling with here is trying to still

protect people from those who should not be giving diagnoses, and obviously the intent is not to stop you doing what you are doing.

If this were taken out, or if social workers had their own act, is that seen—particularly the second one, because some have mentioned that might be a way of protecting those who are performing this function. Or do you think there would need to be specific exemptions for clergy, social workers, designated groups? What is your sense about the best way to get rid of what you feel is an overly broad definition?

Mr Giles: Well, there are some options. You are quite right. The social work profession is trying to gain legislation, actually through the Community and Social Services ministry, because they are excluded from this particular act, and everybody agrees that legislation or regulation is a good idea. So either in this act one could make reference to professions licensed, I suppose, under another ministry or another act, or actually list exemptions.

As to which is the best, I am not really sure which would be better, but somehow it has to be clarified. There are others besides social workers who would get involved in this. I am thinking of pastoral care people, for example, who are not listed in this act, and I am sure they also would be wanting to be in the list of exemptions. Right now there is no way in this act, as I see it, that we can be exempted from this activity.

The Chair: Thank you very much. We appreciate your coming before the committee this morning.

1110

ATTENDANT CARE ACTION COALITION OF OTTAWA-CARLETON

The Chair: I call the Attendant Care Action Coalition of Ottawa-Carleton. You have 20 minutes for your presentation.

Mr Simpson: My name is George Simpson. I am one of the board directors of the Attendant Care Action Coalition. I am also on the Ottawa-Carleton Independent Living Centre. With me are Avril Gunter, a director of the Multiple Sclerosis Society of Ottawa-Carleton, and Don Damiano from Ottawa Care Option.

The Attendant Care Action Coalition, ACAC, of Ottawa-Carleton is comprised of adults with physical disabilities, living in the community and directing their own lives and attendant care services and representative organizations providing attendant care which makes such independent living possible. Our membership includes representatives from the Ottawa-Carleton Independent Living Centre, the Multiple Sclerosis Society of Ottawa-Carleton, the Muscular Dystrophy Association, the Daly Co-op Support Services and Ottawa Care Option.

When the Schwartz report *Striking a New Balance: A Blueprint for the Regulation of Ontario's Health Professions*, came out, many people had objections to its recommendations. It was obvious to physically disabled adults requiring attendant care that such services would be impossible if certain of the report's recommendations were to be put into effect under the bill.

I will turn the second part of our presentation over to Avril, who will talk about the significance of attendant care services.

Ms Gunter: We would like you to understand the relationship between an attendant and a person with a physical disability whom they assist. The attendants provide the hands which enable the person with a disability to carry out the functions of daily living. Most of an attendant's duties do not involve actions which are controlled acts under Bill 43, but others such as bowel and bladder care, feminine hygiene, some injections and the changing of colostomy bags are so defined under the bill.

For someone who is working, and many of us do, services must be performed on time, at home or at work. Only a patient can afford the time to wait around for a nurse to perform intermittent catheterization or bowel disimpaction, and we do not consider ourselves patients. If a medical professional has to perform these services there will be a great increase in the cost to OHIP and it will restrict our ability to direct our own lives. With the help of attendants we can live as productive members of the community.

Paragraphs 26(2)5 and 6 are the things we are objecting to. These would prevent attendants from performing many necessary tasks for persons with disabilities. We feel an amendment must be added to section 28 of the bill which would recognize the following facts: first, that adults with physical disabilities have the right to direct their own lives and, second, that attendants should be exempt from controlled acts in the same manner as household members.

Mr Damiano: In respect to the proposed passing of Bill 43, we feel that due to the individualization of attendant care needs by consumers, an amendment to Bill 43 for attendants in such procedures outlined in the bill should be considered a right, not a privilege, for every person should have the right of choice, consistency and access to his or her care requirements, whatever they may be. In the area of attendant care, we feel we are a community-regulated field, as it includes responsible professionals, administrators of government-funded attendant care programs, family members, consumers and service providers.

Since some of the procedures outlined in the bill are a daily requirement for day-to-day existence by consumers of attendant care services, if Bill 43 is passed without amendment for attendants you will be passing a bill which regulates existence, quality of life, human dignity and the freedom surrounding their own person, therefore disabling their ability to control their own destiny, for living one's life is what makes existence so worth while.

Mr Simpson: I will conclude by saying that we have physical disabilities which prevent us from performing some of the necessary functions of daily living, and thus we need assistance in order to live independently in the community. Any legislation aimed at controlling our attendants is detrimental to our ability to be contributing members of society. Thank you.

The Chair: Thank you very much for your presentation. We have had some extensive discussion at committee and there is a Hansard which has the ministry's response to this point, that has been raised by others. I am going to ask the

clerk to take your names and addresses and we will mail you a copy of that Hansard. I apologize that it is not here this morning. We have it on file. Parliamentary assistant, do you want to have ministry response?

Mr Wessenger: Yes, I think perhaps I should indicate to you that the minister and, I believe, the previous minister have indicated there will be some sort of exemption provided under the regulations for attendant care.

Mr Simpson: That will be included in the act itself?

Mr Wessenger: No, the undertaking is with respect to the matter of regulations. However, regulations legally have the same status, basically, as an amendment under the act. They are all part of the legislation. Legislation includes both the act and the regulations that are passed under that act, so they all are considered legislation.

The Chair: When you read the Hansard you will see that there is commitment from all three caucuses and all members of this committee to support attendant care and living in the community and there is a desire among everyone here to ensure that you have that information. There is no desire by anyone in any way to restrict individuals who can live independently in the community. We will send you along that Hansard and after you receive it, if there is additional information that you think would be helpful to the committee, please feel free to communicate with us in writing.

Ms Gunter: We feel that we should not be subject to regulation. As we said in our brief, we do not feel that we are patients and we feel we have struggled for a long time to get away from being medicalized and do not want this bill to return us to that status.

The Chair: The point you make has been made before at the committee and there has been some discussion in the Hansard as to the difference between personal care and health care services, and commitments have been made to define that and exempt that by regulation. The regulatory development process will also be a part of the advisory council which will be established, and that is included in the commitments in Hansard as well. Thank you very much.

1120

JAY McSPADEN

The Chair: I call Jay McSpaden. Welcome to the committee. You have 10 minutes for your presentation.

Dr McSpaden: Good morning. My name is Dr Jay B. McSpaden. I am a trained teacher of the deaf, a certified audiologist, a licensed hearing instrument practitioner and a professor in graduate programs in audiology and communicative disorders. I am on the medical staff of a hospital and, most important, I am a consumer of hearing aids and assistive listening devices.

I am here today to urge you to not make the prescription of hearing aids a licensed act in Ontario. In my view, making the prescription of hearing instruments a licensed act limited to physicians and audiologists is not in the best interests of the citizen consumers of the province. Rather, it is based upon an overreaction to rumour and myth and is not in the best interests of the government, physicians, audiologists or the hearing instrument practitioners.

Permit me to explain. First and foremost there is no record of a risk of harm to the consumer in the fitting of hearing instruments by professional hearing instrument practitioners within this province. To pretend that the purpose of this proposed clause in the bill is to reduce the risk of harm to which the consumer is subject is to play upon the rumour and myth that such cases exist, that they exist in large and/or significant numbers and that the professional association to which the practitioners belong is incapable of policing its members and their activities. This is not the case. There is no record of such a problem. Therefore the avowed purpose of this bill is obviated and, in terms of reducing the risk of harm, it is a case of chasing ghosts.

Second, it is important that you understand that the technology involved in the identification of the ideal hearing instrument fitting is an extremely dynamic one. It involves keeping current with the latest technological advances. There are counselling aspects of adaptation to the instrument which must be facilitated, close supervision and maintenance of difficult and problem cases and the establishment of the basis for a long-term working relationship which can optimize the communicative efficiency of the aided consumer.

Third, these activities require continuing education and upgrading. They necessitate continual modification and improvement of the knowledge base. They require dedication and commitment, and those activities take time. It is virtually impossible for anyone to keep up with more than one of these fields. To be a physician and keep up with all the advances in technology in the field of hearing instruments is, I submit to you, a truly unrealistic expectation. Yet, if physicians are to prescribe hearing instruments, they must keep abreast of the leading edge of the technology which is completely outside of their area of expertise. If they do not keep absolutely current with the growth of this technology, in addition to keeping abreast of advances in their own medical specialties, the consumers of this province can only be treated to an increasingly aging technology which cheats them, does not optimize their residual communicative potential and in the final analysis does place them at risk of harm by default.

Fourth, these same arguments must be made regarding the professional clinical audiologist. The growth of clinical awareness, improvement in equipment and techniques pertinent to the identification of expanding otopathology and its impact of increasingly complicated contribution to health care places enormous stress upon the clinical audiologist. The impact of an entirely new field of technology, which in itself is continually expanding, is unreasonable for the audiologist, unfair to the government and unrealistic for the patient. The outcome of such a system fosters the practice of the history of the profession rather than to be able to offer to your constituent consumers its cutting edge.

Ladies and gentlemen, I have taught in graduate training programs for the training of audiologists and physicians off and on for more than 20 years. I am well aware of the amount of training in hearing instruments and hearing instrument technology to which they are exposed. With a very few notable exceptions, the clinical audiologist is not sufficiently trained in the cutting-edge hearing instrument

technology to prescribe such instruments in this decade. They may well understand the history of the profession and its technology, but they do not, understandably, have the time necessary to concentrate on the technology which consumers deserve to have available to them in their own quest for communicative efficiency in their lives. This is not anyone's fault. It is simply a statement of fact. If they are licensed to have prescriptive control of these devices, the patient, the government and the consumer will be poorly served.

Licensing the prescription of hearing aids to physicians and audiologists alone ignores the group of qualified, registered, established hearing instrument practitioners who currently conduct their services throughout Ontario. These professionals have steadfastly co-operated with the government in upholding the standards of their profession and the honour of their individual persons. They are an integral part of the hearing health care delivery system within the province and as such they have a vital role to play.

It is important that you understand the current and potential demand for services within this province and the availability of professionals to meet those needs. Those hearing instrument professionals are an important part of the success of the system in Ontario. Without them, I believe the system becomes a logistic nightmare which penalizes the communicatively impaired consumer by forcing him or her into a mechanism in which the delays are unconscionable and the dangers of conflict of interest unrestrained.

The ultimate effect of this legislation is not increased consumer protection. Rather, in my opinion, it guarantees income in perpetuity to authorizing and dispensing audiologists and physicians. It removes any possible question as to the appropriateness of their prescription, as no alternative authority would exist. There would be nothing to compel them to keep pace with the technological advances, as without competition or any real threat of malpractice, quality delivery of service would be defined by them.

Two points need to be made. A hearing aid is simply a tool which, if appropriately used, improves communicative efficiency. Can it cause harm? Certainly it can, as with any tool which is improperly utilized but—and this is critical—that statement is equally true regardless of who fits or dispenses the hearing aid. Regardless of the prescription, there is never a guarantee that it could not be misused and, if so, would not cause a risk of harm. Making prescription a licensed act cannot diminish that risk.

Second, I believe there is a serious misperception afoot here in the province. A majority of the audiologists working in this province are American-university trained. Their exposure to hearing instrument practitioners in the United States does not reflect the quality of these practitioners who have been Sheridan College-trained, who have been evaluated, examined and regulated more highly than almost any profession in this province and who are currently authorizers in Ontario.

This group, the practitioner-authorizers of the Association of Hearing Instrument Practitioners are, as a group, some of the best-trained, most highly professional and most highly experienced specialists on the North American continent. I

travel all over that continent, ladies and gentlemen, and that is exactly correct.

The matter before you is not, I submit, being driven by a real need for consumer protection. The consumers have already spoken and they do not want prescription to be a licensed act. It is being driven, I believe, by a desire for a legislative monopoly which guarantees income without quality control or interference. If you pass this bill unchanged, who protects the consumer then?

I urge you not to make the prescription of hearing aids a licensed act. Properly trained practitioners combined with medical clearance would address any concerns for potential risk of harm or conflict of interest. I would be happy to answer any questions that you have.

Mr J. Wilson: Sir, you touched briefly on the conflict of interest question. From what we are hearing from ministry officials, for the government the issue surrounding the prescription of hearing aids is boiling down more to the fact that there is an inherent conflict of interest in having the same person prescribe and dispense. Could you just comment on that a little further?

Dr McSpaden: Yes, I would be happy to. I have several thoughts on that matter. One of them is that I do not find that similar question being raised about physicians who recommend surgery and then perform the surgery and I do not find it raised about audiologists who are both authorizers and dispensers. It occurs to me that this is a caste system of some sort or other which says that if you actually have a master's degree or above, you can go ahead and do these things and you are not ethically capable of committing a conflict of interest. I do not find that to be true.

I do not see that there is a conflict of interest in an ethically managed and policed organization, and it has been my experience with the existing practitioners' group that it is such a group. So that is the short, Walt Disney version of the answer. There is a long answer that will take several hours if you would like to sit somewhere with me.

Ms Bohnen: To respond to Mr Wilson's question, the ministry's view is that potentials for conflict of interest between the same practitioner both authorizing and dispensing are really handled adequately by the policies of the assistive devices program, at least in so far as the government of Ontario is paying for hearing aids for individuals. Other similar agencies such as the Workers' Compensation Board and the Department of Veterans Affairs no doubt have their own ways of ensuring that there is not a conflict of interest between the prescriber and the dispenser.

Dr McSpaden: May I make one additional comment? I have the ineluctable opportunity to travel all over both the United States and Canada speaking and teaching and whatever. I must reiterate my point that while there are times when what happens at home does not look like it is the best of all possible worlds, these people here in Ontario and the people in Alberta turn out to be the best-trained hearing instrument professionals on this continent. Second to, perhaps, the graduates of the two-and-a-half-year university program in Germany, they are, perhaps, the best-trained hearing instrument professionals in the world.

The Chair: Thank you very much for your presentation.

1130

CINDY HARRISON

The Chair: I call Cindy Harrison. Welcome to the committee. You have 10 minutes for your presentation.

Ms Harrison: I am Cindy Harrison. I am a speech-language pathologist.

Ms McLean: I am Megan McLean. I am an audiologist.

Ms Harrison: I would like to take this opportunity to thank you for allowing me to provide comment on the Regulated Health Professions Act and the accompanying Audiology and Speech-Language Pathology Act.

The Ontario Association of Speech-Language Pathologists and Audiologists welcomes the majority of regulations and recommendations set forth in these acts. There are, however, certain issues that we feel need to be more clearly defined.

As you are aware, the issues that OSLA wishes to pursue further are diagnosis as a controlled act, title restriction, and prescription of a hearing aid as an authorized act. For the purposes of my presentation I would like to address the issues surrounding diagnosis and title restriction.

I do feel that diagnosis needs to be regulated. The act of diagnosis as it pertains to speech-language and hearing is an act requiring a great deal of education, specialization and training. According to OSLA's legal advisers, the legislation as written could prevent me from communicating the results of an assessment directly to my client.

As a speech-language pathologist I routinely provide feedback regarding the speech-language assessment results, associated factors, prognosis, treatment and home programming suggestions. Invariably the individuals and their loved ones have many questions. Following assessment, a great deal of time is spent discussing factors associated with the communication difficulties, the impact of the client's communication challenges on the family, and strategies to deal with the communication difficulties in the home, school, workplace and community.

Significant concerns exist about subsection 26(1) of the Regulated Health Professions Act, which, as currently written, would allow only physicians and psychologists to communicate the conclusion of assessment to the client. The impact of this is potentially enormous. For the patient, this means a visit to the speech-language pathologist or audiologist for assessment, back to the physician or psychologist for the results, and then back to the speech-language pathologist or audiologist for treatment.

A number of factors must be considered in this instance: the financial burden to the health care system, potential delays in treatment, potential increase in clients' anxiety as they await the diagnosis, and the inability of the psychologist or physician to provide complete and comprehensive feedback regarding treatment and prognosis in the areas of speech-language or hearing.

Recently I discussed this issue with a client whose five-year-old daughter presented with a severe speech and language difficulty and has been in treatment in my practice for two years. I would like to share her comments with you, and I quote: "That's very interesting. In our case, our physician didn't feel there was a problem. I had a three-year-old

who wasn't saying a word, and he didn't think there was a problem. It was only after I insisted that I got a referral and got some help. I trust this physician for all medical issues, but he is obviously not informed in the areas of speech and language. How could someone like that have given me your assessment results?

"I also don't think people understand how incredibly stressful this whole thing is. Communication is how we show people who we are. You feel anger, frustration, and real sadness when your child can't communicate. If you had told me that I'd have to wait to get an appointment with my physician to learn the results of what you just spent time doing, I would have hit the roof. If I remember, we spent an hour and a half discussing your conclusions and trying to understand the nature of our child's difficulty. It just wouldn't be fair to do it any other way."

As speech-language pathologists and audiologists we are highly trained to assess, diagnose, and treat varying communication disorders and dysfunctions. We are the most knowledgeable in the areas of speech-language and hearing. Results of the assessment plus the diagnosis, counselling and treatment in these areas should come from us. To fragment this process undermines the idea of comprehensive care for the consumer as well as potentially negating our ability to function autonomously within the scope of our profession.

I would now like to discuss the issues surrounding title protection. I agree that this clause is vital to consumer protection. I am concerned, however, that this clause is open to interpretation. It is my feeling that the legislation should remove any potential confusion or doubt as to the qualifications of the service provider. As you are aware, the historical designation for the profession of speech-language pathology is "speech therapy." Although we now refer to ourselves as speech-language pathologists, the term "speech therapist" is widely used by members of the public and sometimes by other professionals. Since these issues have become increasingly topical, I have been paying particular attention to the use of these terms. It may interest you to note that I found a brochure describing a school-based program here in Ottawa-Carleton in which we were called speech therapists. This was a pamphlet designed and published in 1990.

Recently a client asked me to review an employee benefit package that stated that coverage for "speech therapy" would be provided if services were obtained from a registered "speech therapist." In December of 1990 the mother of a six-year-old boy contacted my office. She stated that her son was assessed by a speech therapist, who stated that he did not require any therapy. Unconvinced, this mother was seeking another opinion. When I asked for the name of the therapist, I was given a name I was not familiar with. I asked if this therapist was a speech-language pathologist. The mother replied, "She said she was a speech therapist." As it turns out, this therapist is not a speech-language pathologist. This child did require treatment, and eventually received service from a qualified professional.

I am continually surprised at the number of people who refer to us as speech therapists. When I am asked what I do, I always reply, "I am a speech-language pathologist." I

tell clients that I am a speech-language pathologist. My letter-head states that I am a speech-language pathologist, and I sign my reports as Cindy Harrison, speech-language pathologist. Despite this, I am frequently referred to as a speech therapist. What concerns me is the idea that an unqualified individual can call himself or herself a speech therapist. The consumer, who is accustomed to this historical designation, cannot be expected to question this credential.

I would also like to comment briefly on the clause in the restricted titles section of the profession-specific act for audiology and speech-language pathology which states that people other than members of the college are prohibited from using the titles of "audiologist" and "speech-language pathologist" "in the course of providing or offering to provide, in Ontario, health care to individuals." I am concerned that the proviso "health care" is too limiting to ensure public protection. Consumers may seek the services of a speech-language pathologist or audiologist in educational, industrial, or community settings, as well as health care. While I understand that the intent of the clause is consumer protection, it concerns me that the interpretation of this clause may lead to protection only in a health care setting. I feel that the amendment of the clause to include title protection in other areas such as industrial, educational and social services is vital to ensure consumer protection.

It is also my feeling that the holding-out clause, subsection 15(2) of the Speech-Language Pathology and Audiology Act, needs to be strengthened to provide more comprehensive protection. Currently the act reads, "No other person other than a member shall hold himself or herself out as person who is qualified to practise in Ontario as an audiologist or speech-language pathologist or in a specialty of audiology or speech-language pathology." OSLA suggests that a more detailed definition of qualifications would more adequately prevent unqualified individuals from implying or inferring a level of qualification which they do not have. I also feel that the protection of the title "speech therapist," title protection in all settings in which speech-language pathology and audiology services are provided, and a more detailed holding-out clause will combine to help the public to distinguish regulated health providers from those who are not.

Finally, I would like to reiterate my support for this legislation. I feel that its impact will be significant not only for the consumer, but also for the professional. I thank you for listening to my concerns in the areas of diagnosis and title restriction. I sincerely hope that your committee will make the proposed amendments to aid us in ensuring consumer protection. Thank you.

The Chair: Thank you very much for appearing before the committee today.

1140

COALITION OF ONTARIO MIDWIFERY AND BIRTH SCHOOLS

The Chair: I call the Coalition of Ontario Midwifery and Birth Schools. You have 20 minutes for your presentation.

Ms Fafard: I am Jenny Fafard and I am speaking on behalf of the Coalition of Ontario Midwifery and Birth

Schools. If you look at our presentation, there is a list of the people we represent at the back of the first section of our written submission. We are a group of birth schools from around rural Ontario.

COMBS is a coalition of schools and groups of educators and students across Ontario representing currently practising midwives as well as many apprentices, clients and activists in the Ontario midwifery movement. Most of us are located outside of Toronto in both urban and rural settings. Some of us have no formal affiliation with other midwifery organizations, whereas others have extensive provincial, national, and international links. We are delighted for this opportunity to provide input since we have not been able to access other avenues to our satisfaction. We enclose the submission we are sending to the ministries of Health and Colleges and Universities because it is the basis of the issues we are going to raise again today. That is the first piece of paper you have.

We are experts in understanding what midwifery is; we are not experts in the legislative process. However, we have the following suggestions we feel will ensure that midwifery remains responsive to the women it was created to serve.

1. Referring to Bill 56, section 3, scope of practice: We note that the location of practice is not addressed. We would suggest that a clause from the definition accepted by the International Confederation of Midwives, the International Federation of Gynecologists and Obstetricians, and the World Health Organization be added at the end. That quote is, "She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service." We also believe that some reference should be made about the midwife's role with high-risk situations. We suggest the addition of the phrase, "When the care provided extends beyond her abilities, the midwife arranges for consultation, referral, continued involvement and collaboration."

2. Referring to Bill 56, section 4: There are several omissions here, including administration of substances by oral methods, catheterization, and oral and nasal suctioning of the newborn infant. Other acts such as nurses' and physicians' acts include specific references to acts such as these.

3. Referring to Bill 56, section 15: We would like to draw your attention to the definition of "midwife" in our position statement, which is, again, that first section of the paper. As you can see from this discussion, the term "midwife" has an important history. The government and the new college of midwifery would be making a gross assumption to think that they have the prerogative to claim ownership over a title which is generic and which is already owned. We do believe that the government can make claims to own the title "licensed midwife" or "registered midwife," however. The college of nurses calls its members "registered nurses" as opposed to simply "nurses."

4. Referring to Bill 56, sections 6 to 14: We need to make it clear that contemporary midwifery has arisen in reaction to the very structure of the various health care professions providing maternity care in Ontario. To structure midwifery in the same hierarchical manner as the other health disciplines is to undermine the very reason for its existence. Fundamentally, the structure outlined in the

bill will entrench inequality and will result in a profession that will be unable to respond adequately to the women it has been called to serve.

We suggest some of the following changes:

1. In reference to Bill 56, subsection 6(1), we feel that the college of midwives should be reflective of midwifery; that is, it should be community-based. Therefore, in order to be representative, the council should be regionally representative. The council should also be reflective of the diversity of midwifery practices.

2. In reference to Bill 56, section 7, we submit that the council should have neither a president nor a vice-president but should be run by consensus, reflecting a feminist approach to organization.

3. In reference to Bill 56, section 8, we submit that in keeping with a feminist approach to organization, there should be no executive committee.

4. In reference to Bill 56, sections 9 to 14, we submit that the members of any committees of the council should be elected from among the members of the college by the members of the college.

5. In reference to Bill 56, sections 9 to 14, we submit that the members of the college and consumer organizations should be free to establish any other committee deemed necessary. We suggest that the following committees should be considered: (a) education; (b) public education; (c) interprofessional relations; (d) intraprofessional relations; (e) client relations; (f) community liaison, specifically with community groups and individuals; (g) competency; and (h) affirmative action, which would address cultural appropriateness.

6. In reference to Bill 56, section 18, we submit that this item should read, "The college may make regulations after approval from the membership." Any changes affecting the practice of midwifery should have input from the membership affected.

7. In reference to Bill 56, clause 18(a), this item should include a reference to substances administered orally.

8. In reference to Bill 56, section 19, we again must submit that the transitional council appointed by the Lieutenant Governor be regionally representative and reflective of the diversity of midwifery practices in this province. Thank you.

Mr Beer: Thank you for the presentation, and particularly for underlining the point of view perhaps of those outside of the Metropolitan Toronto area. I want to make sure that I understood part of your submission. Really, in terms of the way in which the transitional council is functioning, I take it that you do not agree completely with the way this matter is proceeding and are concerned about the structures that you think will see the council evolve as a council similar to the others we have. Could you elaborate a bit on that in terms of some of the points you made in your brief, because we have not had too much on the structure. We have talked a lot about ensuring that midwives are going to be able to practise and that kind of thing.

Ms Daviss-Putt: May I just say that we have a fair amount of history in Ontario in practising midwifery. Some of us have as much as 10 to 15 years, and it has been

very difficult for us to break into the process. It has been continual for several years. We have noticed that as the legislation process has continued and has reaped a certain amount of recognition, it has been increasingly difficult for us to break in, because certain people represent us who we do not necessarily think are representing all of the views right across Ontario.

We think it is really important that you continually go back to those regions by having regional representation. We really believe that midwifery is a very community-based profession, perhaps more so than many other professions that we know, and to the extent that we do not even call ourselves necessarily a profession but a vocation and a calling. It is incredibly important to us that the women we are serving can approach the college themselves, without a great deal of hierarchical structure.

1150

Mr Hope: Along that line, I guess when we were in London we heard from some people who did not want to make this look like a professional organization. They did not want to take away the human dignity of midwifery. In your number 5 is that what you are proposing, that it be brought back, when making changes in regulations, that they be approved by the membership? Is that what the governance of that is, to try to keep it the human element of things instead of the non-professional?

Ms Fafard: Yes, that is part of it. You are talking about by the members, right? The other part of it is that we feel that particularly with midwifery, because it is so community-based, different communities feel different ways about different parts of practice, and this should be brought out, when necessary, through the members. This is not possible if you have an executive committee that is making all the decisions, but if anything involving practice goes back to the members, they can decide what is going to happen. We think that is quite important because the types of practice are so different around the province in different areas.

Mr J. Wilson: I found your presentation quite interesting, particularly your comments in the brief I gather you are sending to the minister about apprenticeship. You do make the point that midwives should be able to choose really their own avenue of training and education, but do you envision sort of final exams before someone would become a registered midwife?

Ms Daviss-Putt: Because of our history in court competencies, we really believe that it is important for a midwife to be competent in what she is doing, and we do believe that our evaluation process has really been lacking. However, we are at the point now where we have been developing our schools and we are starting to have an evaluation process in place. We are developing it with a number of schools even in the States that have an evaluation process, and we would very much like to ask the government's help in evaluating that. We are concerned somewhat that the government is not making use of the present structures, the present schools that we have, in that process.

Mr J. Wilson: And the government would take the lead role, or the college of midwifery, I guess, would standardize—

Ms Daviss-Putt: Right, and it is apparent to us also by the way the college is being set up that it is working at a very different—

Mr J. Wilson: Different model.

Ms Daviss-Putt: Different way than the way in which we had practised for many years in Ontario.

Ms Haec: I would like to actually pursue the point Mr Wilson made, and thank you also for your presentation, because it does raise a number of points that we have had a chance to discuss with different groups. Various people who have come before us have raised the issue that they wanted to make sure that the foreign-trained midwives had access to being midwives here in Ontario. Possibly ministry staff, through the parliamentary assistant, could clarify this, but it is my understanding that in fact the college will be working with the various groups out there to establish the criteria under which midwifery will be practised here in Ontario. Am I under the correct assumption?

Ms Bohnen: Are you referring to the pre-registration program, which I believe the committee heard something about, that will assess the qualifications of current practitioners?

Ms Haec: Yes.

Ms Bohnen: Then you are correct.

Ms Haec: Possibly for the presenters you could expand on that.

Ms Bohnen: You may be aware that there will be a pre-registration program for current practitioners, which will provide a way for them to become registered as midwives in Ontario.

Ms Daviss-Putt: We are very much aware, but what we are somewhat concerned about is that that will not be a continuing, ongoing process. We think that apprenticeship is a route for midwives that is actually a very viable one, and probably one that is more community-based than a very centralized school. We really believe that route of entry should not be cut off, that people should always have the option of beginning in their community and starting to apprentice with various people there and then choose their own form of acquiring the core competencies, have an evaluation process and become a midwife.

Ms Haec: The standards for practice were being set so that in fact some of these concerns might be included in what the college sets down as standards for practice?

Ms Bohnen: Yes and no. I think it is important to say that the model of midwifery education that is envisioned for Ontario after the transitional period is not an apprentice-based system, it is a system based on a professional midwifery education in an educational institution. However, there is a very strong desire and intention to have it decentralized so that people can do components of the program in many locations throughout Ontario, but it is not an apprentice-based educational model.

Mrs McLeod: I think my colleague also had a question. I am prepared to waive to him. I know we are running out of time.

Mr Grandmaitre: No, go ahead.

Mrs McLeod: I am intrigued with your comments about non-hierarchical organizations, particularly with a community-based focus. The question I have is whether that becomes more costly and whether that is a concern for you. Looking towards a college which is a group of newly regulated professionals, whether just your cost of putting that kind of process in place may be prohibitive for you.

Ms Daviss-Putt: Our experience in the last few years is that it is incredibly important for the central community that is proposing the midwifery legislation to become responsive to the rest of the province. We believe that if there is a major problem with our representation because we cannot go down to Toronto, it is time for us to start to use telecommunications. Our very coalition has started that system. We communicate by telephone. Many of us are not represented here today because we are in Ottawa, but our members from Windsor and from North Bay and from Powassan, from right across the province, are here because we have made telephone calls in the last six months preparing this submission. To us, it is more important that we are representative and have fewer meetings perhaps in one central place and use telecommunications. Yes, I believe it is possible.

Mr Grandmaitre: You referred to having your own evaluation process. Can you elaborate on this? Who would do this evaluation, your own people or outside?

Ms Daviss-Putt: No, we would have no problem with the college doing the evaluation. I have no problem with that at all. As a matter of fact, the midwifery integration planning program has come up with a number of very creative suggestions about how to do the integration of the present practising midwives. It is just that we believe that that process should be extended. There are already apprentices now who have trained who are almost full midwives. They would like to have the ability to do the same kind of evaluation procedure that the present practising midwives have been offered, and we believe that the apprentices of the present apprentices should be allowed to do that as well, if they have chosen to become apprentice midwives as opposed to midwives who have trained in an institution that is central.

The Chair: We appreciate your taking the time to appear before us. If at any time in the future there is additional information that you feel would be helpful to the committee, I know that you realize you can submit briefs in writing to our clerk. Thank you very much for appearing today.

The committee recessed at 1158.

AFTERNOON SITTING

The committee resumed at 1400.

ONTARIO MEDICAL ASSOCIATION

The Chair: I call the Ontario Medical Association. Leave a few minutes at the end of your presentation in case committee members have any questions. You have 20 minutes.

Dr Guzman: I would like to first of all say how pleased we are to be able to speak to you this afternoon on this issue which we have been so involved with for so many years. My name is Carole Guzman. I am a practising physician in the Ottawa area and I have been chair of what we used to call the Health Professions Legislation Review committee, in the old days, since its inception about eight or nine years ago.

With me is Dr Ted Boadway, who I am sure many of you know is the director of health policy at the Ontario Medical Association and has also been involved with this particular activity since those very early days. We have served on this committee together.

I think from the beginning it is public record that we have recognized the need for this legislation in order to standardize and update existing legislations and also to bring under legislation those health professional groups which had developed really over the last 10 or 15 years and worked with us, side by side, in a professional capacity.

We are fully aware that the primary focus of the legislation is the protection of the public and certainly we have tried to contribute to that aim throughout these years in our activities in dealing with this legislation. As part of our mandate as an association, our motto or our mission statement, is to serve the medical profession and the people of Ontario in the pursuit of good health and excellence in health care.

We are also fully aware that we have a mandate to serve our members, so in some respects one could say we have a conflict of interest in these mandates. What we have tried to do over the course of dealing with this legislation is to deal with that challenge and to try and bridge those conflicts. In fact, the legislation itself has competing goals because it is to protect the public, but at the same time, any legislation of this type has to be aware of the true justice that must be given to those individuals who are caught up in it. So we feel that the outcome has been a good balance between competing goals for all those considered. We have by no means achieved everything we have wanted along the way and we accept that. I think that is true of every group and it is inevitable.

I think perhaps what is astonishing in this legislation is, in our perception, how little there is left that we feel needs addressing. It is a massive piece of legislation of a totally revolutionary concept.

We have chosen today to address in our brief four issues. We wish to speak in the few minutes we have on three of these issues. The first one deals with wording and is self-explanatory in our brief. We will just skip over that for now. The other three areas we wish to spend a couple

of minutes on are diagnosis, the harm clause and the quality assurance committee.

First of all, if we go to the diagnosis issue, I think it brings us to consideration of the concept of controlled acts, which I think really was quite a revolutionary concept, from legislation which controlled individuals in what they did to legislation which controlled the acts that were done by any number of individuals. This was a very difficult concept for all of us to grasp initially and a lot of time and effort went into trying to define what these acts should be.

We at the OMA have had some experience in trying to define this in the crass activity of setting up fee schedules, but our fee schedules consist of thousands of items. The question is, how can you reduce these to harmful items that can be put in legislation? So a lot of work went into this. We consulted within the profession; a lot of consultation went between professions, outside the professions, and it became clear to us that one of the most risky things we do as physicians is what we call diagnosis. There has been a lot of angst back and forth about this term and I want to just spend one minute to describe—and there are further descriptions in our brief—what we mean, as physicians, by a diagnosis.

Very simply put, if you come to me—I am a chest physician—and you have a cough or shortness of breath, what happens is that I will take a history. That means I will ask you everything possible about it briefly. This may take quite some time. I will do a physical examination and then come up with a list of the possible causes of that shortness of breath. Is it due to something in the heart or the lungs or the stomach or the head or wherever? That is the role of the physician. And then I will order the appropriate tests.

So if I make the wrong list at the beginning or if, as I comb down to the ultimate cause of your cough or shortness of breath, in the course of that process make an error, significant harm is done, because everything that follows from that is the management or the treatment or the dealing with that cough or shortness of breath. The diagnostic process for a physician includes the taking of the history and the physical examination, the forming of a list of possible causes of the abnormality, the ability then to know the nature of these ideological factors and to choose from them what the most likely are and then to order the appropriate tests. So even though the tests might be dangerous, the most dangerous part is if I make errors along that diagnostic process.

Once the physician has decided in his or her judgement that this is the diagnosis, then communication with the patient and subsequently with others becomes very important. Many other players in the field will also use that information to help the patient understand, so they in turn will communicate the diagnosis to the patient.

I work in a team concept in rehabilitation and once the diagnosis is made, many of those people who work with me, the psychologists, the physiotherapists, the nurses and so on, will carry on in their own spheres to help that patient

further understand the meaning of the diagnosis and the way it affects their function.

We just wanted to clarify for you that our perception of what we do in diagnosis is a risky business. We would make a suggestion that, as you have to deal with this, you consider returning the definition to its original in the controlled acts, which was simply "diagnosis."

The second issue we want to talk about is the harm clause. In making up the controlled acts scheme, some were concerned there may be holes, there could be dangerous things not covered in that list which had been made and there was no precedence for such lists. There was never any absolute certainty that things had not been left out, and there was the concept then of making a clause that would cover this eventuality and would cover perhaps those who might do things that were harmful by getting around the acts. This was so-called the harm clause.

Effort went into wording the harm clause and this proved to be difficult. There were some groups prior to the previous first reading in the Legislature who felt that it restricted their ability to counsel patients because of the way the harm clause was worded. Certainly, that was not the intent. I do not think anybody at any point ever intended social workers, clergymen and other counselling professions to be in any way inhibited by this legislation.

We are supportive of the concept of a harm clause, first, because we feel that it probably has to be there to prevent abuse by non-regulated professionals or others who might try to find their way around it. Second, we must remember that this legislation puts a very high standard of performance on regulated professionals and unless you have some way of ensuring that those who are non-regulated can be prevented from doing harmful things, this in a way will denigrate the legislation.

We are supportive of the presence of a harm clause and in thinking about the wording, we were favourably disposed to the wording put forth by the Ontario Chiropractic Association to you people recently. They took the previous wording but have adjusted it somewhat, added "unjustifiable" and "significant." We feel this is probably as good as you are going to get if you decide that a harm clause is necessary and if you are looking for wording that will satisfy the needs of the legislation and not inhibit legitimate activities of unregulated practitioners in the other fields.

The third issue I wish to address at this time is the quality assurance committee. I think this has been an extremely positive feature of this legislation and I think you all know that the chairman of your committee was in fact one of the key proponents of this particular part of the legislation being put in.

The reason we think it is so positive and are not criticizing it here but rather complimenting it is that it is a new focus. I think it should be clear to the committee members that it is a different focus from all the other committees. All the other committees under existing legislation focus on punishment and deterrent, penalizing for wrong doing. This particular part of the legislation focuses on encouragement of quality of care, encouragement of maintenance of competence. It leaves the flexibility for colleges to devise ways in which they are going to ensure that their own

professionals maintain their competence, and this will differ from college to college or from group to group.

We feel that it is extremely important to maintain this in an open and flexible way. Within our own profession, the whole area of competency is under intense study and intense research. You might at first say, "Surely you know when a physician is competent or not," but it is not that easy. Somebody can test my knowledge, can give me an exam and test my knowledge and even my skills, can watch what I do. But it is very hard to measure attitudes, it is very hard to measure whether I apply in my daily practice what I know. I may know how to treat high blood pressure, but is that what I actually do in my practice?

How we measure competence and how we encourage maintenance of competence in such a rapidly changing field as health care is an area of intense study. In fact, an example of this is that the nation's specialty body, the Royal College of Physicians and Surgeons, has recently assigned \$1 million to the study of maintenance of competence and measurement of competence within our profession. The college of family practice nationally is also involved in many different projects to try and get a hold on how we do that.

Until this area becomes more defined, we think that to codify how it is to be done would be inhibitory to the evolution of proper competence measurement, proper competence assessment. We are bringing forth our full support for these particular clauses in the way they are, because we feel they have the flexibility and will encourage people to move along in these areas of quality assurance and competence.

In conclusion then, we are supportive of the legislation. We have highlighted in our brief a few of the areas which we feel are in need of further discussion. We will be submitting a further brief on some of the technical issues which arise out of the government's proposed amendments, and also on the subject of incorporation which has not really been addressed up to this point but which we believe should be. We will be submitting a written submission on that.

We would be pleased to answer any questions.

1410

Mr Jackson: Thank you, Dr Guzman. Good to see you again. I could not help but note on page 2 you say not what is wrong with this legislation but rather "how little there is left to complain about." I guess after four weeks we have certainly heard a bit that people have been complaining about.

One of the items which has been brought to our attention, very cogently I might add, is the concern that chiropractors have with respect to their current practice, which would be adjusted to ensure that their scope remains within the spinal areas and not the outer extremities. I would like to hear from you if you support that, and if so, why? How will that have an effect on the physicians? I would assume that the physicians would then be responsible for the manipulations of the arms and legs and feet and those kinds of things that are the outer extremities they are looking at.

Dr Guzman: I am going to let Ted carry on from here.

Dr Boadway: I would first like to know if you intended a pun when you said that their scope would be adjusted, or whether that was unintentional.

When we have been dealing with this issue all along, it has always been difficult to know what adjustment means, because adjustment for a spine is considerably different from adjustment for an elbow. In your spinal joints there is a definition of adjustment which means that with a short thrust you carry it beyond the usual range of motion of that joint, but you cannot do that with your elbow. When your elbow gets out there, with any thrust you cannot carry it beyond that point unless you are willing to break something. So it is very difficult to think that an adjustment of a spinal joint is the same as an adjustment of a knee joint or an elbow joint. In a diseased joint the same thing pertains in that you cannot take it beyond the normal range of motion for that particular joint. So whether it is health or disease, the definition of adjustment would be quite different, whether it was in the back or in a peripheral joint.

Mr Owens: We have heard a number of depositions from the nursing profession with respect to the legislation containing the phrase "on the order," and it is their wish that phrase be removed in the process of our amendments. I wonder if you have any comments on whether we should entertain that amendment or leave it as is—that nursing functions be carried out on the order of a physician or a qualified health practitioner?

Dr Boadway: I think you should entertain it and you should think about it very carefully. Much of what nursing does is on the order of someone else at the present time. If you are in a post-op situation where people need to have dressing changes, anything from dressing changes right through to intensive care unit work, someone is usually in charge of that and that is usually the physician who did the operation, and the rest of the team works on those orders.

It is a question of whether or not the scope of practice would be expanded legitimately with that. Quite frankly, we believe that in most circumstances there are protocols within institutions and there are also standing orders which look after much of this. In fact if you go back about 10 years, nursing's role has been rapidly evolving. Now, in intensive care units, to stay with the same example, they are doing very significant things, very important acts with great risks associated with them, and doing them extremely competently. None of that is in question.

Right now they do that on the order of, and in the future if they were to do that on the order of, it would not impair their ability to do them. So I think it is possible in fact for you to go either way. What you want to look at first and foremost is where the protection of the public is greatest. At the present time the public is well protected by being on the order of the person who is the principal performer.

Mr Beer: I would like to go back to your comment about diagnosis and I wonder if for the record you could just tell us how you saw that being worded. What were you replacing in terms of your original recommendation that I guess you made to the review? How is that framed in the context of these controlled acts?

Dr Boadway: This has always been a problem in the review, right from the beginning. We have always had difficulty with this; everybody has had difficulty with this. So, congratulations.

Our recommendation in the very first place was to put down the simple word "diagnosis" and that would look after capturing the things doctors do quite adequately. So we would not have trouble with our profession, making sure they were caught. But a lot of other people found there would be a problem with it.

Our recommendation was that you look at people who are diagnostic practitioners—and there are clearly people other than ourselves who are diagnostic practitioners—that they simply be given the right for diagnosis according to their abilities, and clearly they are able. So our original recommendation was that the word be "diagnosis" and that it be granted to those who are diagnostic practitioners.

Mr Beer: That would be reflected then in each act. Was that the sense, that you would have to repeat that in the other bills we have before us for those who clearly perform some sort of diagnostic procedure?

Dr Boadway: Yes. At the present time, if it is a controlled act, each controlled act that is granted to a group is in their particular act. And, yes, it would be one of those repeated in those acts.

Mr J. Wilson: Given what you have just said, and it also appears on page 5 of the brief concerning the diagnostic controlled act, perhaps I could ask the parliamentary assistant a specific example. For instance, in the case of speech-language pathologists, why are they not given the controlled act if the OMA seem to have no objection to it?

Mr Wessenger: I refer that to ministry staff.

Ms Bohnen: The review concluded that the appropriate characterization of what speech-language pathologists do was not diagnosis but rather assessment. That was the reason. Of course, among the regulated professions there are professions in addition to medicine that have been authorized to perform that controlled act, but not all of them, obviously.

Mr J. Wilson: Maybe I could ask the professional opinion of the witnesses. It is one of the examples that comes to mind very frequently with witnesses, the speech-language pathologists and the diagnostic controlled act. Did the OMA have any objection or did you deal with that profession specifically?

Dr Boadway: No. We were very careful never to support or not support any professional group in its quest for diagnosis. It was not our position to judge. We have never asked for that position and we do not take the position that we should be able to judge now. In order to determine whether someone is a diagnostic practitioner, we think you can look at how people are trained, the kind of training they have, the kind of clinical experience they have, the availability they have to diagnostic tools and their experience in making differential diagnosis, which Dr Guzman had explained to you. To make a diagnosis, there is a skill set one must have, which we have outlined in our brief. If someone possesses that skill set, then he is a diagnostic practitioner.

Mr J. Wilson: That is refreshing because some groups, whether they were referring specifically to the OMA or the College of Physicians and Surgeons of Ontario, certainly would accuse you of having protected that. It is refreshing to hear that you did not take a stand on any of the particular professions.

1420

Mr Jackson: I have concerns about whether a certain treatment will now fall outside of the scope of practice and therefore the physician will be called upon to perform that practice. It raises the question of their ability to perform that. There is a lot of presumption. An example is a physiotherapist performing under the supervision of a physician not necessarily a qualified physio. Another example is a chiropractor. I use "chiropractic" in the case of readjusting of the bones in the hand by a chiropractor with the training, versus a doctor who the legislation says should be doing it but may not have the training. We have satisfied the intent of the legislation, but how can we ensure that the actual treatment is done at that competent level?

Dr Roadway: Physicians manipulate peripheral joints every single day in this city and every other city of this province and they do it in conditions which are very dramatic even and not ones where people can walk through the door. Physicians manipulate joints after serious injuries. They manipulate joints in conjunction with fractures and they manipulate joints for arthritic conditions. They manipulate locked knees, frozen shoulders, diseased elbows. The thought that you have just raised that physicians may not be trained to manipulate joints is a new one to me in that it is something we do in very dramatic conditions, as well as lesser conditions, on a daily basis.

The Chair: I would like to thank you very much for your presentation before the committee. I know you are aware that if you feel there is additional information that would be helpful through the committee deliberations that you will submit a written brief or communicate through our clerk.

ONTARIO MEDICAL ASSOCIATION,
SECTION OF OPHTHALMOLOGY

The Chair: I would like to call now the section of ophthalmology of the Ontario Medical Association. Please come forward and introduce yourself for committee members and the purposes of Hansard. You have 20 minutes for your presentation. We would appreciate it if you would leave a few minutes at the end for questions from committee members.

Dr MacInnis: I am Brent MacInnis. I am a medical doctor and an ophthalmologist, which is a specialist in eye medicine. I have asked for special consideration from the committee with respect to our section. I am also the chairman of professional affairs, the section of ophthalmology of the Ontario Medical Association. We felt there were sufficient grounds with respect to the differences between our concerns as a section, with overlap with other opticians and optometrists as well as other areas of medicine, and there were specific areas of the proposed legislation that

address concerns with respect to the eye, the visual system and also with respect to the supporting adnexal structures.

When it comes to the proposed bill for medicine, there are several sections specific to our area of medicine. One is that a member is authorized to perform the diagnostic clause, which is communicating a conclusion identifying a disease as the cause of symptoms or signs. Another is that they perform a procedure on tissue below the dermis, in or below the surface of the cornea. Others are: administering a substance by injection, applying or ordering the application of a prescribed form of energy, prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eyeglasses and other simple magnifiers, and allergy challenge testing.

I would like to spend just a few moments on each just to refresh the minds of the committee with respect to how that would concern ophthalmologists and later spend some time on the proposed definition of the scope of optometry and also opticianry to determine whether there is some input we may have that may be of use to you.

When it comes to the first one, communicating a conclusion identifying a disease as the cause of symptoms, I think it is important that we understand that an incorrect diagnosis, as Dr Guzman has alluded to, can convey a wrong conclusion and can lead to very devastating consequences.

The example I have chosen here is that if you have an ocular tumour, for instance a metastatic carcinoma from the breast or from the prostate or from the lung, that can metastasize or spread to the eye and be seen as a retinal detachment overlying that tumour mass. The wrong conclusion, obviously, can have the implication with respect to the general health of the individual as well as to the ocular health of that individual. So a wrong conclusion may be blinding and indeed may be fatal if it is carried to the nth degree.

What people have a tendency to forget with the definitions as they appear is that the detection of problems can be performed in the assessment portion of somebody's scope of practice. For instance, if you look at the proposed Optometry Act, the assessment of the eye and vision system, what is controlled is communicating a conclusion. They can still see a retinal detachment. What they cannot do is convey the conclusion that there is an underlying carotid tumour that is metastasized from the lung and is causing that retinal detachment. That in no way precludes a complete assessment and examination of that.

I would like to defer a little bit with respect to that and come back to that when I define some of the problems associated with other scope matters.

I think it is equally important to understand that there is definitive harm in invading the integrity of the dermis and also the integrity of the cornea. The cornea is the front surface of the eye that is responsible for the refracting strength of the eye and focusing rays, in addition to the other ocular apparatus that are present, so the integrity, if it is disturbed, if it is central, will immediately impair the central visual acuity and cause disturbance to that. I think any procedure that violates the integrity of the surface of the cornea really has to be protected from individuals performing procedures upon it.

The other thing to keep in mind is with administering a substance by injection. There is not only the substance that has the potential harm but also the vehicle the substance is in and its preservatives which can be administered for diagnostic or therapeutic reasons. I think the brief from the general OMA has addressed this issue quite adequately. I would also like to point out that there are of course threatening diseases with any violation by an injection with respect to hepatitis, AIDS and other communicable diseases.

One area that is especially important with respect to ophthalmology is the administration or application of prescribed forms of energy. You can have ultrasound energy that can destroy the part of the eye that is responsible for secreting the aqueous that gives the intraocular pressure. You can have laser energy administered to destroy tumours, to close off abnormal blood vessels. There is a multitude and host of prescribed energy forms that have implications that can produce great harm if administered in a way that is not controlled.

Prescribing or dispensing contact lenses is currently something that only licensed practitioners are capable of doing and we fully concur that the implications of corneal ulceration or permanent visual loss are such that this again should be a controlled act and the prescription and dispensing of these contact lenses should be only by licensed practitioners.

Allergy challenge testing is something, just by the inherent nature of the words involved, that involves a challenge. Unless you are equipped medically to handle the ultimate response, which is anaphylaxis or a severe shock to the allergen test, it is something that again should be controlled.

Some things we are running into now in ophthalmology are that the preservatives used in contact lens solutions and in drops are the same preservatives that are used for hepatitis, influenza, tetanus and other forms of immunization. So somebody who is determined to have a sensitivity to that preservative may indeed run into problems and should not be treated with this immunization. I recently had in a dental hygienist who could not receive her hepatitis vaccination because of a thimerosal sensitivity induced from contact lens wear. The implication is there. If you are not aware of it being as a vehicle in other medicaments and other vaccines then the medical implication may escape you.

I would like to go into some of the more controversial areas. The proposed bill for optometry has defined the practice of optometry as "the assessment of the eye and vision system and the diagnosis, treatment and prevention of vision and oculomotor dysfunctions of the eye."

We, as a section, believe this definition is too restrictive. We believe that optometrists indeed do diagnose and treat disorders, but the disorders they treat are refractive diseases and disorders of the eye. We have met with the registrar of the college of optometry and we have met with the review and it is our opinion that we cannot come to a consensus with respect to a modifier. We cannot go along with no modifier, giving the diagnosis of all diseases and disorders and dysfunctions of the eye and visual system in that it indeed is beyond the current scope of optometry and

does not reflect adequately what the existing status of the profession is.

1430

We presented a brief in April of this year and in previous years along the process of the review, and feel that "refractive diseases and disorders" adequately characterizes the nature of the scope of optometry. We are comfortable with that. To us, the acceptable definition of optometry might be: The practice of optometry is the assessment of the eye and visual system and the diagnosis, treatment and prevention of refractive diseases and disorders of the eye and of sensory and oculomotor disorders and dysfunctions of the eye and visual system. We feel that is a compromise we can live with, and one we have hammered out over the course of years.

I have enclosed, within the appendix, an addendum 1. This addresses the scope issues, other diagnostic features that optometry has felt in the past fell outside the realm of refractive diseases and disorders but which we feel are all within the realm of refractive diseases and disorders. I would again like to stress that this does not limit the assessment of the eye and visual system. An assessment will detect symptoms and signs of cataracts, retinal detachment, glaucoma and all these things. It is communicating a conclusion identifying a disease as the cause of the symptoms that is the controlled act. Many of the voiced concerns of optometry appear to fail to make this distinction. If the proposed definition is accepted, then of course the licensed acts and controlled acts would have to be adjusted accordingly.

With respect to opticianry, we have no objections to the proposed bill as it reads, as long as dispensed subnormal vision devices, contact lenses or eye glasses comply with the prescription which we indeed write, and conform to the patient such that we are happy and the patient is happy. I thank you very much for your time.

Mr Beer: Thank you for your presentation. You touched on a number of the questions in relation to optometry. We have had a number of submissions from their association, as well as from individual optometrists. They see Bill 60 as limiting what they are going to be doing. If we look at what you do today and optometrists do today, and if the acts went through as they are, without the changes that you are proposing, what is it, in your view, that it is then giving to an optometrist to do? What are some of the things that they would be able to do, from your perspective, that they would not be able to do if your definition was in place?

Dr MacInnis: If you take, for instance, an individual who has a different length eye, so that one eye is stronger than the other, one eye may be more far-sighted than the other eye is, which may be conducive to having a turned-in eye. What can be done, and should be done, if it is a young child under the age of visual maturity, which would be under the age of seven, eight or nine, is that the child should be treated with glasses and should be treated with patching or occlusion therapy. That corrects for the imbalance between the two eyes and puts a patch over the stronger eye to make the child use the weaker eye.

That would be a refractive diagnosis where, because of the difference between the two eyes, the brain suppresses the image from the weaker eye and turns that eye off and it becomes blunt or amblyopic, as we call it. By correcting the difference with the glasses and by stimulating the poor eye by making them use the poor eye with the correction of the glasses, that is a refractive treatment that is treating a refractive disease and disorder of oculomotor dysfunction as well.

Mr Beer: And an optometrist could do that today?

Dr MacInnis: They currently do that. But that would be a disease, as opposed to a disorder or dysfunction that under the proposed bill they would not be able to do. So the current bill is restrictive in that fashion. Whereas if you encompass the refractive diseases and disorders, then that would adequately encompass what they currently do.

Mr Beer: The other question is the number of ophthalmologists in the province. Are there sufficient numbers to handle what, in the view of the optometrist, would be the cases they would have to refer because they would not be able to do certain things? The argument has been that they can do those and that would help with the cost and that there would be a difficulty with referrals. What is the sense of your association?

Dr MacInnis: Currently there are 350 ophthalmologists in the province of Ontario, which represents a ratio of approximately one in 30,000, which is the ratio that is recommended by the World Health Organization, the Department of National Health and Welfare and our own association. We feel we are in a manpower-balanced situation that is very good.

You have to remember also that primary care is provided not only by ourselves and by optometry but by general practitioners. If you come in with a corneal foreign body, for instance, in virtually every community the family doctor is on call for the emergency department and plucks out foreign bodies, treats infections and does all these things not only on a 9-to-5 basis but on call and on a weekend basis, provides coverage for that sort of primary eye care. Certainly optometry does provide primary eye care within a lot of the smaller communities in Ontario and certainly is appreciated by the family doctors and by the ophthalmologists in the community.

As a rule, ophthalmologists and optometrists on a personal level get on very well.

The Chair: Thank you very much for your presentation before the committee today. We appreciate your coming out. If there is any additional information you think might be helpful to the committee, you will communicate with us in writing.

ONTARIO CHIEF PSYCHOLOGISTS ASSOCIATION, EASTERN REGION

The Chair: I would like to call now Ontario Chief Psychologists Association, Eastern Region. I ask that you come forward and introduce yourselves for the committee. We would appreciate it if you would leave a few minutes at the end of your presentation in case any of the committee members have questions. You have 20 minutes for your

presentation, and I would ask that you begin your presentation now, please.

Dr Blouin: We are pleased to make our presentation today on behalf of the eastern region of the Ontario Chief Psychologists Association. I am Dr Arthur Blouin, director of psychology at the Ottawa Civic Hospital. My colleague here is Dr Sal Colletta, director of psychology at the Ottawa General Hospital.

We will try to keep our comments quite brief. We are certainly pleased to bring our perspective from the general hospital psychology departments to this committee, and we would like to say at the outset, I think, that we are basically very much in support of this legislation. We think that in general, as our written document indicates, the act represents a progressive approach to the delivery of health care in Ontario.

There are four principles that are important here. First is the increased public protection from unqualified health care providers. Second is the encouraging of the provision of high-quality health care. Third is enhancing the public ability to exercise freedom of choice in health care services. Fourth is encouraging the flexibility of roles which the various health care professions can play in the delivery of health care. We are looking forward to seeing these principles incorporated in the new legislation. We are of the opinion that certain components of the legislation regarding psychology are best addressed in the manner that we are about to discuss.

The first area is title protection. First, in maintaining two of the major principles of the legislation, the public protection and freedom of choice principles, we believe that the term "psychologist" should be protected, as is now written into the legislation. We believe that "psychological" and "psychology" should also be protected, because we do not believe that the general public can clearly distinguish between a licensed psychologist and someone who holds himself out or advertises himself as providing psychological services.

In Ontario now, to become a licensed psychologist requires a doctorate in psychology, a minimum of at least one year of post-doctoral training and supervision and, at the end of that process, passing stringent written and oral post-doctoral exams. So for the public to distinguish between someone with that level of training and someone who advertises as providing psychological services is a difficult one. We do not think it is an abstract issue in semantics; it is a very practical one and important not only for the users of psychological services but also even for those who refer to psychologists for psychological services, physicians and other health care workers.

1440

So we believe there is a general difficulty in distinguishing between the levels of training of individuals providing services in this area. Unlike other health care professions, the end point of most of our training programs is the doctoral level and the required stage for independent practice has been accepted as the licenced psychologist. The general public, we feel, is not clearly aware of this, and to protect the public and ensure that free choice is also

informed choice, we feel that these terms should be protected from misuse. In addition, we feel that the public will become increasingly confused as to who is and who is not a qualified psychologist if the title protection is restricted only to those providing services to individuals providing health care.

For example, if someone—as the legislation I believe would now allow—presents himself as a psychologist in a newspaper column or on a radio talk show but is not qualified to be a licenced psychologist in the health care system, that would be okay. He could hold himself out as a psychologist but the public would readily come to believe that the level of training of that person is representative. When the public goes to the health care setting, we ask the question, “Will the general public clearly be able to make an informed and free choice in distinguishing between someone offering psychological services and someone trained and licenced as a psychologist?” Unless the title is protected for all services offered, the ability to make these distinctions in the mind of the general public will, we believe, become very difficult. So we see this as an issue of freedom of choice, informed choice, and protection of the public against misunderstanding in those terms.

The second area we would like to address is diagnosis. We generally agree with the OMA to return to the simple term “diagnosis,” and we believe that there are areas that psychologists have been trained to diagnose. In a general hospital setting, much of the work of a psychologist is to act as a consultant to other professions. This may be to psychiatry, other medical disciplines and health professionals. In carrying out this responsibility, the role is frequently that of a diagnostician, and the referring disciplines want us to clarify and/or make diagnoses. The reports we write specify diagnostic information, and treatment plans are based on these diagnoses. It is important to patients and to referring disciplines that psychologists continue to make these diagnostic decisions in the areas that psychologists have been trained to make them.

In many areas in the field of mental health, the psychologist is simply the best-trained professional in the team to make the kind of diagnosis that is being sought. In the general hospital setting, psychologists provide services in the area of assessment, which is essentially descriptive; diagnosis, which is essentially fitting symptoms into known and well-defined syndromes with specific names; and treatment and consultation.

So it is important that psychologists are legislated to make diagnoses in order to provide the general public with optimal care. We state again, however, that we feel the communication of conclusions does not have to be restricted to the psychologist, but that the authorized act, the act of diagnosis, should be. So in summary, and briefly, as representatives of the chiefs of psychology in Ontario hospitals and, in particular, chiefs at general hospitals, we strongly urge you, in the new legislation, to protect the terms “psychological” and “psychology,” along with the title “psychologist.” We would also recommend that the diagnosis be a controlled act of a psychologist, as proposed in the current legislation.

Mr J. Wilson: We have had many non-doctoral psychologists—anyway, people practising in the field of psychology—appear before this committee, and we have had some psychologists themselves, the PhD, appear and express similar concern to continue the protection of the terms “psychological” and “psychology.” There is a memorandum of understanding signed between the two groups. My concern is that if we go ahead and include in this legislation the protection of the two additional terms and there is never an agreement reached over the next 18 months with the non-doctoral practitioners, we may be cutting off something that may be useful to them. We clearly had evidence that there are a number of non-doctoral psychologists practising, in northern Ontario, for instance, where they never see a PhD or claim to seldom see a PhD. We cut off some terminology that under this new act they would be able to use, for instance hanging out on their shingle that they are providing psychological services. To be perfectly frank, I am worried that might lose some of the impetus to come to some agreement about who will be future members of the college of psychology. Do you want to comment on that?

Dr Blouin: My understanding is that there is a committee struck to address the issue of bringing in or somehow allowing that group to come into legislation as well. I think our recommendations would not cause any greater restriction on those people as they are providing services now, because I think the current legislation does protect those terms. We are certainly not of the opinion that their activities should in any way be curtailed, but I think it is very important, in general, that the public be aware of the distinction between a fully licenced psychologist and anyone else, whether it is the non-PhD provider of services in psychology or anyone else who can offer himself as providing psychological services. That is a very great problem for the public.

Under this legislation, anyone can say “services in psychology,” not just those people who do not have a doctoral degree and are not registered as licenced psychologists. That we see as a big problem for the public. That is the very fundamental issue. We would be very much in favour of having those who are providing services incorporated in some way and given the scope of practice for which they are trained and accountable for as well. I think that would be a far better situation. In the meantime, it opens a door to anyone besides those people.

Ms Haeck: I think you are probably well aware, Dr Blouin, that we have received quite a number of presentations, be it from the master's-level psychologists, your own group, as well as the unregulated group. Can you comment at this time on the whole perspective as has been opening up to the public? “Access to a variety of services and making the public aware” is one of the comments that you have made about what a psychologist does. Because of the array of people who in fact do counselling, what kind of consumer education would you foresee having to take place to make it clear what all of the differences are going to be? Because there is really a vast array, as our representations can well attest.

Dr Blouin: We would be in agreement with the general principle of opening up the services. I think as psychologists we all run into the confusion of someone you meet not being clear as to what it means when you say "psychologist." My understanding is that under this legislation we could be in the position where, outside of the health care setting, people who are not licensed to practise could call themselves psychologists.

Within the health care system you have to be licensed to call yourself a psychologist. Then you have a whole other group of people who are unregulated who do provide psychological services. Then you have a whole other group of people who have no training in psychology who may provide some sorts of services and ask for fees for those services. I think under this legislation the amount of public education required to clarify that would be enormous. It is a very difficult distinction for the public to make under the proposed legislation.

1450

Mrs McLeod: I am not sure whether to direct the question to the presenters or to ask counsel for some comment, but it is in relation to the issue you have just touched on again, title protection outside of a health care setting. It was my understanding that certainly the intent of the legislation was that a controlled act would be a controlled act wherever it was carried out, whether in a health care setting or not, and that controlled act and title protection necessarily go hand in hand, so that title protection would also extend outside the formal health care setting. Do you have a concern that this may not in fact be the case?

Dr Blouin: Yes. I am not that well versed on the nuances of the way all of the forms of the act read, but my understanding was that the term "psychologist" was restricted to health care and that people who are providing activities that are totally unrelated to health care and may not have the qualifications could still present themselves as psychologists and if they are not doing the acts and they are not providing health care, they could still call themselves psychologists. Now, if this was, for example, a newspaper column, the public perception could easily be distorted into thinking that person is a psychologist representative of psychology. When they go to the health care system, there is great confusion. That is what I would be concerned about. If there are provisions to correct that, then my concern is not justified, but that is how I have understood it.

Mr Hope: Mine deals around the title protection issue. You have been referring to the ones with the PhD and the MA levels, and then you are saying there is another segment of society out there that is using these titles. Do you have any statistics at all of how many people without MAs are out there using this?

Dr Colletta: There are none as yet. Under the new legislation as it is written, if it were passed, following on points made in the presentation, individuals who would be providing services that would not fall under the narrow definition of health care that is in the proposed legislation could present themselves as being psychologists and, at the very least, could present themselves as providing psychological

services or psychological consultation, which the present legislation does not allow to happen. As the law stands now, the only people who can use the terms "psychologist," "psychological" or any derivative of the word "psychology" are licensed psychologists. There are none now. It is a question of if the legislation goes through as it is written. It really does open the door to individuals being able to provide services that would not be well controlled.

The Chair: There were questions for the parliamentary assistant to clarify.

Mr Wessinger: I would like to have ministry staff clarify this point.

Ms Bohnen: I would like to clarify first what the current state of the law is under the Psychologists Registration Act. Section 11 of that act restricts to registered psychologists the use of the title "psychologist" or titles, designations, descriptions incorporating the words "psychological," "psychologist" or "psychology." It is not restricted to any particular kind of service. However, there is an exception from that general title protection, first for legally qualified medical practitioners, second for a person in the course of his employment by the government of Canada, government of Ontario or a university. So we already have many exceptions. Many psychologists are employed in academic and government situations. Many people providing psychological services are employed in those settings and there is no restriction on their use of the title.

In the proposed legislation there are two kinds of protection. First of all, the use of the title "psychologist" and any variation, translation, etc, of it is indeed restricted to individuals providing or offering to provide health care to individuals. But it does not say "health care settings"; it says "health care."

I think the presenters are quite right in saying this legislation would not prevent a newspaper columnist from describing himself or herself as a psychologist even if not registered in Ontario as a psychologist. Quite frankly, it has not been the government's intention to try to stop cocktail party uses, academic uses, media uses of these titles, but really to restrict how these titles are used where they can truly mislead people, which is at the front line where health care services are being delivered.

Of course, supplementing the specific title protection is the additional holding-out clause which in not very many words, and far fewer words than it seems some groups would like, does prohibit individuals who are not members from holding themselves out as persons qualified to practise as psychologists. I hope that clarified it a little bit.

Dr Blouin: Just in responding to that, that is one of the issues. If people can write a newspaper column and call themselves psychologists, it is going to be very difficult to make members of the public aware when they go into the health care system as to what a psychologist is.

The Chair: Thank you very much for your presentation.

OTTAWA ACADEMY OF PSYCHOLOGY

The Chair: I call the Ottawa Academy of Psychology. You have 20 minutes for your presentation.

Dr Bush: Thank you, Madam Chair. I am Clarissa Bush. I am the past president of the Ottawa Academy of Psychology and I work at present in a chronic health care facility in Ottawa. My colleague is Wendy Richardson, president elect, also working in a general hospital in the Ottawa area. I am presenting on behalf of the Ottawa Academy of Psychology.

The Ottawa Academy of Psychology is concerned that introduction of Bill 63 may reduce the public's ability to obtain good health care. I would like to invite you to glimpse with me a scene that could take place if the Psychology Act is passed as it is now written.

The year is 1993 and the Regulated Health Professions Act is in place. Due to very serious professional misconduct in 1992, my licence was permanently withdrawn at the beginning of the year. I have lost my hospital job and am faced with the prospect of trying to earn a living another way. After careful reading of the Psychology Act, I place the following advertisement under the new heading "Psychological Services" in the yellow pages, "Clarissa Bush, doctorate in clinical psychology, expert in neuropsychology: Assessment and treatment of all types of cognitive and memory problems; psychological support and therapy to care givers and families; remediation and rehabilitation."

Over the next year, the college of psychology received several complaints from members of the public who, aware that their third-party health insurance covers treatment by psychologists, used my services and were then unable to obtain reimbursement. The complainants receive a letter from the college informing them that I am no longer licensed in Ontario but pointing out that as I am not contravening the law in any way, there is, unfortunately, nothing the college can do to restrain my activities. This is because, in contrast to the situation which has prevailed since 1960, the terms "psychology" and "psychological" are no longer restricted to registered psychologists.

It is now 1994. Business is a little slow, but I have heard that the educational field is quite rewarding and, recalling that some of the courses I took as a graduate student dealt with child psychology, I decide to branch out. Under the yellow pages headings "Educational Consultants" and "Psychologists," I insert the following advertisement, "Clarissa Bush, PhD: Educational psychologist; individual evaluation and remediation."

Although my limited experience may put some of my early educational clients at a disadvantage, I am sure that through reading textbooks and a process of trial and error I will soon learn what is needed. As Bill 63 provides only for the restriction of the title "psychologist" to individuals providing health care, I am fairly sure that by labelling myself as a psychologist only in the area of education I can enlarge the scope of my business without getting into difficulties with the college.

The Ottawa Academy of Psychology, whose goals are to improve contact among local psychologists and to increase the public's understanding of the profession, is in strong support of the intentions and almost all of the provisions of the Psychology Act. However, we submit that the effect of section 15 regarding restricted titles will be

the opposite of what was intended, leading to confusion and extra distress and suffering on the part of a section of the public which is already rather vulnerable.

1500

One of the purposes of changing the way in which health professionals are regulated is to provide more information to the public to allow them to make an informed choice about their own care and to protect them better by improving the way in which the regulatory process operates. As a group of people whose main objective is to help others, we wholeheartedly endorse those goals. However, we submit that the goals are not in fact furthered by the proposed Psychology Act as it now stands. Many people will be unable to draw distinctions between shades of meaning, ie, psychologist versus psychological, such as those employed by the act. People seeking our services are, by definition, in emotional distress and will therefore be even less able to do so.

Another point which causes concern is that the term "health care" is left unelaborated in the act, presumably to be defined by the courts. Historically, courts have tended towards narrow rather than broad definitions and this might mean that psychologists providing educational, correction, management consulting and other non-health services would be essentially unregulated.

In summary, in order to provide more accurate information to the public and to guarantee that professionals providing psychological services are properly regulated, the Ottawa Academy of Psychology recommends the restriction of the terms "psychology" and "psychological" to registered psychologists and broadening of the act to include all psychologists practising in Ontario.

Perhaps I can apologize for the redundancy after the last presentation.

Mr J. Wilson: You do not need at all to apologize for the redundancy, because I am going to ask you the question I asked the last group. Just to expand on it a bit and play devil's advocate, would it not be the case that, say, the non-doctoral psychologists, the MAs, perform psychological services now?

Dr Bush: They do, under the supervision of psychologists, and perhaps I could point out that, except for the people who were grandfathered in when the Psychologists Registration Act came into force, there are no non-doctoral psychologists in Ontario.

Mr J. Wilson: I think the committee understands that when I use that terminology.

Dr Bush: Yes, they provide those services, but they do so under supervision and they are not allowed to advertise themselves as providing those services.

Mrs McLeod: I would also follow up and use what you have referred to as redundancies as a chance to seek some further clarification on those central issues. I am going to ask ministry staff, if I may, about the two examples that have been used of advertisements, just to follow up on your explanation given to the last presenter. As I understand it, the first ad would in fact be allowed under the proposed act because it does not use the term "psychologist," but the second ad, describing yourself as an "educational

psychologist," would not be allowed because it represents a holding out as a psychologist and therefore someone able to do those controlled acts, even though it is in a non-health care centre. Have I understood your explanation correctly?

Ms Bohnen: Yes. I think it is important to point out that the scope of practice of psychology as it appears in this legislation, again, is not restricted to services provided in health care settings. The kinds of diagnostic activities, let's say, that psychologists perform with children are often provided in an educational setting. The use of the title "educational psychologist" would not mean there was not health care psychology and therefore a title entitled to be restricted to registered members of the profession, as you have said.

If I could just chime in with this, I think part of the difficulty in grappling with title protection with a profession like psychology is that, as you know, many non-psychologists are providing the same or very similar services to what psychologists are providing. What the review tried to grapple with is suggesting title protection that, while it protects the public, is appropriate to a system in which the service is not monopolized by any particular group. You do not want to make it harder for the public to locate and assess the services provided by people who are not members of the regulated profession. That is not public protection either, so I think that is why this is so hard.

Dr Bush: I would like to respond to that, if I may. Certainly we recognize that there are masses of people out there, far more than there are psychologists, providing excellent services that the public needs, and it is very far from our intention to restrict anybody's access to services that they need, but our position is that if the act is adopted as it is now written, it would make it much harder for people to distinguish between psychologists and other people—and they might be choosing to look for somebody other than a psychologist—but it makes it less clear rather than more clear.

The Chair: Thank you very much for your presentation.

CANADIAN SOCIETY OF HOSPITAL PHARMACISTS, ONTARIO BRANCH

The Chair: I call the Canadian Society of Hospital Pharmacists, Ontario branch. You have 20 minutes for your presentation.

Mr Babcock: I am Kelly Babcock, and with me is Cheryl Bishop. We are president and president-elect of the Ontario branch of the Canadian Society of Hospital Pharmacists. We represent nearly 1,000 pharmacists practising in Ontario's health care institutions today. I would like to thank you for the opportunity to provide input for the proposed Regulated Health Professions Act and its related legislation. In general, we are very supportive of the proposed changes to the regulation of health professions in Ontario. However, we do have two areas of concern.

First we would like to discuss the issues that deal with Bill 61, the Pharmacy Act, and the Drug and Pharmacies Regulation Act. I feel the best way to illustrate this viewpoint is with the following case scenario.

When you receive a prescription from your physician for an antibiotic to treat an infection you have, you get it

filled at your community pharmacy. Your prescription will be interpreted and dispensed by a licensed pharmacist. Thus you are protected by the competency standards set out by the Ontario College of Pharmacists and can feel confident that you will receive the quality of services you expect from your pharmacist.

Unfortunately, you are not guaranteed this protection when you are in a hospital. You could be in an intensive care unit receiving lifesaving medication and not receive any input from a licensed pharmacist. This is because the practice of pharmacy in Ontario's hospitals is not currently regulated through health professions legislation. There is an exemption clause, a loophole, if you wish, in the Health Disciplines Act and in the proposed Drug and Pharmacies Regulation Act that excludes hospitals from the provisions of these acts. In brief, the act states, "This act does not apply to (a) drugs compounded, dispensed or supplied in and by a hospital...for persons under health care provided by such hospital."

We are a little bit concerned about that, because other provinces do not have this type of legislation and it has been in Ontario's legislation since 1953 and has been the subject of much debate. We believe the situation is not in the best interests of the public, since it can and does result in pharmacy services being provided to our province's hospitalized patients by people who are not registered pharmacists—that is, people who are graduates of a pharmacy program but not licensed in Ontario—possibly by registered nurses or by pharmacy technicians. We estimate that there are approximately 10% of people representing themselves as pharmacists in Ontario's hospitals today who are not licensed with the Ontario College of Pharmacists and therefore are not really allowed to call themselves pharmacists. In fact, there are about 30 hospitals that do not have even the services of a single licensed pharmacist, even on a part-time or a consultative basis.

We see this situation as inconsistent with the legal requirement that every patient in the community must be serviced by a licensed pharmacist. Thus, it can lead to potentially lower standards of pharmacy service in hospital settings compared to that in our community, and we feel that the hospitalized patients are entitled to better protection than this.

We have stated our position a few times in various documents and through the various legislative review processes, and basically we believe that the supply of drugs—that is, the distribution of them only—to hospital inpatients and bona fide outpatients should continue to be exempt from the act. Second, the pharmacy services in hospitals should be directed by a pharmacist licensed in Ontario and accountable to the Ontario College of Pharmacists. Third, those hospitals unable to secure the services of a pharmacist would be dealt with on a case-by-case basis by regulation granting temporary exemption from the act. This is how it is done in many other provinces.

1510

The Ontario College of Pharmacists supports our view. They have recently stated that they agree with the present exemption and that drug supply in hospitals be retained but that the pharmacy service itself must be directed by a

pharmacist who is licensed in Ontario and accountable to the college for his or her professional activities.

The Ontario Pharmacists' Association also agrees with this. They feel it is quite unusual that the public at large has to be serviced by a properly qualified pharmacist but those patients in a hospital do not receive such a privilege.

The Ontario Hospital Association has had a differing view until very recently. We met with them a couple of months ago and we discussed this issue at great length. In reality, they have come to the conclusion that there may be a better way of dealing with this issue than the current exemption clause.

Basically, if our position is stated, we feel the following objectives will be met: first of all, to protect the hospitalized patient from unqualified persons acting as pharmacists or claiming to be qualified to provide a pharmacy service; second, to protect the hospitalized patient from poor pharmacy practices; third, to allow the provision of safe and effective drug distribution practices when a legally qualified pharmacist is not present, for whatever reason, and fourth, to permit the continued application of innovative and cost-saving pharmacy practices in a hospital setting.

We have developed a proposed wording of the Pharmacy Act and it is available to you, I think, in the second section. It is on a separate document. This was our initial attempt at rewording the document with potential words. We would definitely want to be involved with the Ministry of Health and the Ontario Hospital Association and the various pharmacy organizations in developing exact wording, but we have pointed out the fact that we think it is relatively simple to provide all parties with what they want and still have licensed pharmacists in hospital while providing for those hospitals which cannot hire pharmacists the opportunity to distribute drugs. Therefore we feel that if the concept is adopted, the interests of the public, especially the hospitalized patient, will be protected.

The second thing we would like to comment on is in Bill 43, and our only major concern is with section 30: "No person shall use the title 'doctor'...in the course of providing or offering to provide...health care to individuals." There are a number of exceptions listed in the subsequent section: chiropractors, optometrists, physicians and surgeons, psychologists and dentists. However, many pharmacy practitioners in Canada today hold doctorate degrees, either a PhD degree or a PharmD degree. The holders of these degrees are frequently employed in senior clinical positions in Ontario hospitals and provide excellent leadership in the profession as teachers, researchers and practitioners in the field of drug consultative services.

The Ontario branch believes strongly that members of the Ontario College of Pharmacists holding these degrees should have their credentials acknowledged by permitting the use of the title "doctor."

Therefore, in summary, we have two areas of concern: first of all, the exemption clause, we want hospital pharmacy practice to be regulated so that we ensure that the public, mainly the hospitalized patient, has its interests protected; second, that members of the Ontario College of Pharmacists with doctorate degrees be allowed to use the term "doctor" in their practices.

Are there any questions?

Ms Haeck: Thank you very much for this presentation. It does add an interesting perspective to an area I have not heard very much about so far. I have a small hospital in my own riding and I know it does not have a hospital pharmacist who is exclusively there, say, on an eight-hour shift. In fact, he is a volunteer. I would say he is not totally a volunteer. I would assume there is some remuneration. But this gentleman does run his own pharmacy and does put in a few hours every week to deal with the pharmacological needs of the patients in that hospital. What he is doing would then contravene this, in your opinion, or your suggestion?

Mr Babcock: No. What we are stating is that we realize that there are not going to be too many hospitals that have a 24-hour pharmacy service. In fact, I think there is only one in Ontario. Drugs still have to be distributed outside normal, if you want to say, pharmacy hours.

What we are proposing is that the distribution as such—the count, pour, lick and stick, as it is well referred to in the old pharmacy colleges—of getting pills from the big bottle into the little bottle and out where they belong should be allowed to happen without the pharmacist being there. However, we feel that a pharmacist should be responsible for ensuring quality assurance mechanisms to ensure that, first, the procedure for doing that by whoever is doing it is done properly and that proper audits are there and, second, if the pharmacist is available that, of course, the pharmacist be supervising. We just realize that it would be impossible to have that in all hospitals 24 hours a day.

Mr Beer: Through the parliamentary assistant, I would just like to get for the record, with respect to the review's decision not to include hospital pharmacists, was it simply because of the existing situation it was felt that was the best way to handle it, or were there some other considerations brought to bear?

Mr Wessenger: I will ask ministry staff if she could comment on that item.

Ms Bohnen: Quite frankly, I cannot remember whether the review specifically considered any change to the existing and long-standing exception for hospital pharmacies. I could get that information for you.

Mr Beer: I know we will have a chance to speak to Alan Schwartz and can ask him at that time.

Mr J. Wilson: Is there a body of evidence now that indicates harm is being done because hospital pharmacies are currently exempt?

Mr Babcock: There are existing situations—for example, at a large teaching hospital where there are plenty of pharmacists—where the actual director himself is not a licensed pharmacist and does not seem to think they have to become pharmacists. The Ontario College of Pharmacists has sort of stayed away from hospitals due to this loophole.

I know the law states that if you want to be called a pharmacist, you have to be licensed with the Ontario College of Pharmacists. However, we also know that there are pharmacists practising today—pardon me, people who

have graduated from pharmacy who are practising today—in hospitals, big and small, who definitely do not have a licence and are calling themselves pharmacists, and that the college is not, I guess, enforcing the rule, if you want to call it that. So there definitely is the potential for it to happen, and it does happen.

Mr Johnson: Following the same questioning, in rural Ontario and in the north it is often a cost-saving measure for smaller hospitals and medical centres to dispense with a pharmacy technician as opposed to a pharmacist. What would happen if pharmacists did not want to go to some isolated community to do this? If what you suggest were to become law, that would exacerbate the situation and would indeed increase the cost, would you not think, for these communities?

Mr Babcock: We are not stating that what you have described initially is impossible to do. Currently there are lots of hospitals that are having the distribution of drugs—and I must reiterate that this does not mean the interpretation of the prescription but the actual distribution of drugs from A to B—happening quite frequently without a pharmacist being there. We do not have any problem with that, provided a pharmacist sets up the guidelines for how it is handled and does various audits to make sure the drug is appropriately dispensed.

There are numerous situations. I happen to have a hospital in Perth where we have a registered nurse providing the distribution services to the hospital. I provide, through my department, a pharmacist who on a consultant basis goes out once a week, first of all, to ensure that the policies and procedures are up to snuff and that everything is going quite nicely in the hospital, and, second, to provide some type of drug utilization monitoring. For example, you talk about costs. The pharmacist can come in there and see if the drugs are being used appropriately in the hospital and then hopefully make suggestions and recommendations that will actually provide patients with the most cost-effective therapy.

So we do not want to stop the distribution of drugs as such. We want to make sure, if there is any interpretation present, that it is done by a licensed pharmacist so that in case there are any problems, the Ontario College of Pharmacists can at least do something about them.

Mr Owens: Are you concerned, with the advent of pharmaceutical companies coming into hospitals and admixing IVs and packaging unit-dose prescriptions, that your jobs are being deskilled and that this legislation will, if passed without your amendments, aid and abet that deskilling of your profession?

Mr J. Wilson: Say yes; it's good NDP terminology.

1520

Mr Babcock: I would think a pharmacist's job is certainly misinterpreted. I think everybody feels that dispensing is the function of the pharmacist. We quite strongly believe that is not going to last long; if we just dispense pills we are not going to live long.

We do believe, however, that there is a long need for ensuring that the rational drug therapy is provided to the patient, and that is where we feel pharmacists themselves have the strongest input. Those are the things that we want

to make sure are regulated by the Ontario College of Pharmacists. Currently that is not the case. That is what we are concerned about, not so much the distribution.

The Chair: Thank you for your presentation.

JANISE JOHNSON

The Chair: I call Janise Johnson. You have 10 minutes for your presentation.

Ms Johnson: I am Janise Johnson. I am a general staff nurse at the Children's Hospital of Eastern Ontario and I work in the neonatal intensive care unit. I have been there for 14 or 15 years. I would like to thank you for the opportunity to make this presentation to this committee.

My submission to the Regulated Health Professions Act comes as a patients' advocate. I have nursed the public for over 30 years and have some grave concerns about the deterioration of the delivery of health care in this province. Bill 43 must be amended.

The care we give the public can either be fragmented like a wilted flower, with every health care professional plucking at the petals delivering his specialty, or we could attempt to keep the individual person or family whole as a beautiful, healthy blossom. This must be achieved to obtain the optimum in health care delivery.

The majority of people who require access to the health care system are uninformed, new immigrants, aged and weak, or in a trauma or crisis situation. The education of the public to this complex system of health care should be undertaken by the nurse. The nurse is well informed and sees the patient as a whole individual with numerous problems. Communication between the nurse and patient must continue to remain open.

On a patient's admission to the hospital, a physician will do the preliminary examination and the diagnosis. This will create a whirlwind of activity around the patient, with medical consultations, laboratory and X-ray workups, possible ultrasound visualizations, etc. Continuity of care is often lacking. The patient and family may be overwhelmed by all the diagnostic procedures. They need the nurse to teach, explain and orchestrate the various examinations and treatments within their physical and emotional state.

I work in a neonatal intensive care unit. We have from 20 to 25 babies who are critically ill. The staffing for the unit from 4:30 pm to 7:30 am is one physician and 13 nurses. We work as a team, explaining to families the condition and treatment of their infants. If the nurse's voice were muffled, a large void would exist.

The nurse must remain the patient's advocate. This is the only medical professional who is with the patient 24 hours a day, 365 days a year.

In the last few weeks, the government has wisely amended the "prescribed" person. This must also include all nurses. The nurse keeps a constant vigil over patients in emergency departments, medical and surgical wards, labour and delivery, operating and recovery rooms, intensive care units and psychiatry. Nurses must not have their hands tied by having to obtain an order before they initiate treatments. We have been educated to respond to a crisis.

In a neonatal intensive care unit, if we have an infant who has a cardiac arrest, the nurse immediately starts CPR

and then telephones the physician. If we delay in our resuscitation, we may have a brain-damaged child. All nurses must have the prescribed power to establish treatment that they have been taught to do. This will save lives.

I am also concerned about the dispensing of medications. Under Bill 43, only pharmacists may dispense medications. This is going to be extremely costly to OHIP. Pharmacists will have to remain in the hospital on a 24-hour basis.

At the present time, if a patient comes into emergency in the middle of the night presenting with a headache and a temperature and the physician's diagnosis is possible meningitis, the nursing supervisor goes to the night pharmacy cabinet to obtain the prescribed antibiotic. The supervisor will deliver the medication to the nursing unit and the bedside nurse will start treatment as soon as possible. Prompt administration of many drugs can save hundreds of lives.

Another concern I have is the management of labour and delivery. This must become a controlled nursing act. Labour is a long process. First babies are often born after 24 hours of labour. The nurse is always in the case room monitoring foetal heart rates and assessing the progress of labour. The physician is notified only if there is a problem with the infant or the mother and when the mother is ready to deliver. Nurses must be licensed to do vaginal examinations, monitor external and internal foetal probes and control epidural anaesthetics. With these skills, a nurse assists the physician and the family in the delivery of a healthy infant.

Midwives should have nursing background. During pregnancy a disease process may surface, for example, gestational diabetes. If the midwife had a broad educational background prior to specializing in midwifery, she would be able to recognize the medical problem and encourage the mother to seek a physician's care.

All nurses must be accountable to the patient, the college of nurses and the employer. Accountability must not be restricted to the professionals giving hands-on care only.

The nurse administrator is responsible for staffing our health care institutions and must do this within budget guidelines.

The present treatment of illness has become so aggressive that often time is not available to give any more than the essential care. This is frustrating to the patients and the nurses and is often one of the main reasons for nurses leaving the profession.

The staff ratio between nurses and patients on a heavy medical floor on a day shift can be one nurse to six patients; on nights, one to 10, and sometimes even one to 20. In homes for the aged it is one nurse to 75 patients. The ratio of staffing in intensive care units is much better, but these patients are more acutely ill and require more nursing care. At times even these ratios become unsafe. The bedside nurse should not have to lower her professional standard and be liable for inadequate staffing.

Physicians, dentists and midwives can perform many of the 13 controlled or hazardous acts independently. Nurses can perform none independently. Instead, they must have an order of another member of the Regulated Health Professions Act or a prescribed person, who might be another nurse selected by the college of nurses. Nurses must be

able to perform those acts within their scope of practice as legitimate practitioners without fear of possible litigation.

The nurse could become the primary health professional to introduce the patient to the health care system. Studies have shown that nurses can provide 60% of the services now provided by general practitioners under the current legislation. Nurses in North America perform many controlled acts independently, efficiently and cost-effectively. Also at a lower cost to OHIP, the nurse would have time to speak to the patients and then refer them to the appropriate numerous health care providers.

As well as outpost nurses in the north, outpatient departments in hospitals work on this type of system. Why could it not be developed in every community in Ontario? Unfortunately, the Regulated Health Professions Act as it now stands will not provide this autonomous practice for nurses.

Concerning the effects the Regulated Health Professions Act will have on the profession, we could be found guilty if we contravene Bill 43 and fined \$25,000 or jailed for six months, or both.

Nurses have always been accountable to the patient, the profession and the employer. If a nurse is fired for any reason, the college of nurses must be informed. The nurse stands to lose her job, profession and dignity. Many of the professions that are seeking self-regulation are going to be placed in this unenviable position.

Nurses are renowned for putting their patients' needs before their own, but now nurses are aware that they must also protect their own livelihood. All professions will be in triple jeopardy. This may reduce the number of students who enter the health care industry in the future.

I am pleased to bring my concerns to this committee. I trust the government will study this and all the submitted briefs and that you will formulate and amend the Regulated Health Professions Act to best serve all the citizens of Ontario in the delivery of health care.

1530

Mr Beer: With respect to the question around labour and delivery, we have had a number of submissions from midwives and groups that favour the legislation as it stands. Do you think then that in order to be able to practise midwifery, one must be a nurse?

Ms Johnson: Yes, I do. I work in an intensive care neonatal unit and see the results of some tremendous deliveries. These can be full-term infants and asphyxia and birth trauma can occur in the last stages of delivery. If a midwife has a broad educational background, I think she or he would be more likely to give better care than somebody who has done a specialty prior to a broad background.

Mr Hope: Dealing with the question of dispensing medication, in the presentation given before you today—

Ms Johnson: Yes, it was very interesting.

Mr Hope: —does that rest your mind at all?

Ms Johnson: I think the pharmacists have a legitimate concern, and nurses, because if we contravene anything that is going to occur in Bill 43, we are actually putting our licence in jeopardy if we are dispensing the drugs. All sorts of responsibilities have been thrown at us and we wonder if legally we have the responsibility to do this or whether

we could be fined. This is going on in every hospital in Ontario probably, that nurses are dispensing drugs, and I think the pharmacists have a genuine concern, as we do.

Mr Wessenger: I would like to have staff do some clarification on this item.

Ms Bohnen: I think it is important to note that dispensing drugs is a controlled act that is authorized to physicians as well as to pharmacists, and that controlled act, like all the others, can be delegated by physicians and by pharmacists, based on what you just heard from the hospital pharmacies, as well as what you have heard from nurses. It sounds as if hospitals more or less work in the sensible way in which they will continue to work, in which pharmacists are responsible for establishing and monitoring the processes by which drugs are actually dispensed and, when pharmacists are not there, nurses or other appropriate health professionals dispense the drugs to patients, pursuant to a delegation.

The Chair: Thank you very much for your presentation.

COMMUNITY HEALTH NURSES' INTEREST GROUP

The Chair: I call Eleanor Soulodre. Welcome. Please introduce yourself to the committee.

Ms Soulodre: My name is Eleanor Soulodre. I am a public health nurse. Although it does not state so in your agenda, I am here today to represent the Community Health Nurses' Interest Group. With me is Beth Townsend. She is the acting senior nursing officer in the Ottawa-Carleton health department and she is also the president of the Community Health Nurses' Interest Group. Also with me is Helen McGuire, a public health nurse in the high-risk prenatal program in the Smiths Falls area.

The Community Health Nurses' Interest Group is made up of approximately 1,800 nurses across the province. It is an interest group within the Registered Nurses' Association of Ontario, which presented to this committee on August 13. The CHNIG is in full support of the RNAO's position regarding the Regulated Health Professions Act. However, we do have an additional concern that is of the utmost importance to community health nursing.

Let me begin by saying that the CHNIG is in complete agreement with the basic underlying principles of the Regulated Health Professions Act. Our main concern focuses around the fact that health promotion has not been included in the scope of practice statement within the Nursing Act. "Health promotion" is a term that is not always clearly understood and is often thought to be synonymous with prevention of illness.

Although the two are closely linked, they are not the same. Let me see if I can clarify that for you. Health promotion is approach behaviour while prevention is avoidance behaviour. Health promotion seeks to expand positive potential for health, while prevention seeks to thwart the occurrence of illness. Even in dictionary definitions, there is a distinguishable difference between "prevention" and "promotion." "Prevention" is to keep from occurring while "promotion" is to help or encourage to exist or flourish. Prevention has been included in the nursing scope of practice statement, and that is a very positive thing

and very appropriate. However, the CHNIG feels strongly that health promotion must be included as well.

In the document *Striking a New Balance: A Blueprint for the Regulation of Ontario's Health Professions*, the recommendations and intent of the Health Professions Legislation Review are clearly explained. Within this document, the scope of practice statement is described as outlining each profession's area of permitted practice. By excluding health promotion from nursing's scope of practice statement, it is implied that health promotion is not one of the expected roles of the nurse. However, the Ministry of Health has mandated health units to provide health promotion services in the mandatory health programs and services guidelines. Public health nurses make up the largest group of professionals in health units, and therefore the health promotion role falls largely to them.

The Ontario government has clearly recognized that the Band-Aid approach to health care is no longer sufficient. We just cannot afford it. The Premier's Council on Health Strategy has identified a change of focus to health promotion as a crucial strategy in the provision of cost-effective health care. We must promote healthy lifestyles in order to have a healthier population that will not continue to drain our health care budget.

If nurses are to effectively co-ordinate with other professionals in the delivery of health promotion services, then it must be clearly stated that health promotion is in fact a role of the nurse. Consumers also have the right to be made aware of the area of practice of each professional so that they may make informed choices.

There is no question of the importance of health promotion in the future of our health care system. The government has identified this and has directed many nurses to focus their practice on health promotion. The CHNIG does not feel that health promotion is something that only nurses should do. Nurses are, however, qualified to provide the service to the public and are presently doing so. If health promotion is not clearly communicated as being part of nursing's scope of practice, nursing services will not be utilized to their full potential. It is our hope that this committee will give serious consideration to the inclusion of two words, "health promotion," in the scope of practice statement within the Nursing Act. That concludes my presentation, Madam Chair, and I am now prepared to answer any questions.

The Chair: Thank you very much for an interesting presentation.

Mr J. Wilson: I certainly agree that it is interesting. I think it is the first time the concerns of community health nurses have been brought to the committee's attention, especially wanting to include the terminology "health promotion." Perhaps, first, you could give the committee a feel for some of the programs and some of the activities you take or promote in the area of health promotion. Second, what sort of practical example would be of the effect of not including "health promotion" in the general scope of practice statement?

Ms Soulodre: To answer your first question, nurses are providing health promotion services to all age groups

in the community. Some examples of this would include prenatal classes, where nurses are promoting health in pregnant women and therefore also in their unborn child. In the process they are also preparing parents to adequately care for their new child and to encourage healthy relationships within the family.

Another example would be occupational health nurses providing stress management sessions in the workplace or school nurses teaching a variety of subjects, including such things as self-esteem, assertiveness, nutrition and that sort of thing. Another example might be mental health nurses who are helping to develop support groups in the community. Those are just some of the examples of the health promotion services that nurses are offering.

1540

Mr J. Wilson: Do you feel there would be a practical effect of not including the terminology in the scope of practice?

Ms Souldre: My understanding is that the purpose of the scope of practice statement is to accurately describe the scope of practice of the nurse. I think if you do not include this you are not accurately describing the scope of practice of the nurse. When you are trying to communicate to the public, the consumer and other professionals what the role of each of the professions is, if you do not include health promotion within the nursing scope of practice, you are not communicating that. As a result, I think nursing services may not be utilized to their full potential.

Mr Beer: Do you know whether the concept of health promotion was recommended as part of the scope of practice of nurses in the initial proposals made by your association?

Ms Souldre: That is a good question. My understanding was that originally the Registered Nurses' Association of Ontario did request that health promotion be included. Correct me if I am wrong. My understanding was that the feeling of the of the HPLR was that a lot of the professions were involved in promoting health, and rather than including it in everyone's scope of practice, it would not include it in anyone's scope of practice. I am totally in agreement with the fact that many health professionals are providing health promotion services. I think in a lot of the cases it is sort of a peripheral thing. They have a main focus and a peripheral thing is that they provide health promotion services.

That is the case with some nurses as well. Their main focus lies elsewhere. Health promotion is a peripheral thing. But with many nurses their main focus is health promotion. I do not think that is the case for a lot of the health professionals, so I feel strongly that it needs to be included in nursing's scope of practice statement.

Mr Hope: Just to elaborate on that and dealing with the Band-Aid approach towards the health care system, if I am understanding it properly you are saying that if we do not put the other mechanism in there as a preventive issue, and as the public health nurse is the one who delivers it to our school systems and to our seniors, then we are really not fixing the problem of helping people. We should be promoting healthier lifestyles in order to achieve long-term care, the multi-year plan and other plans that are out there.

Is that what you are trying to strive at? That is what I am really trying to understand.

Ms Souldre: Yes, that is exactly what we are trying to say. It is very important that we promote health, and I think that has been identified many times. The fact is that we are doing it now. We are providing many health promotion services now, so it seems only fitting that it would be included in the scope of practice statement.

Mr Hope: It should be expanded upon.

Ms Souldre: Yes, it is definitely something to be expanded upon in the future.

Mr Owens: Just to play the devil's advocate for a moment, in terms of the types of activities you perform, such as going into schools and examining kids and things like that, do you think the diagnosis clause is not more problematic for you than having health promotion not included in the scope of practice?

Ms Souldre: I think there are a number of concerns that we as community health nurses have with the RHPA. We are a subgroup of the Registered Nurses' Association of Ontario and we are in full support of its submission to you. I believe they spoke to you on August 13 and that was one of the things they brought up. Rather than reiterating that, we thought we would bring forward what our concern was. I have a slightly different focus from the Registered Nurses' Association of Ontario. Yes, I am in agreement that diagnosis is problematic.

The Chair: Just to clarify, what we just heard you say is that you are in support of the RNAO brief and this is in addition to that. Is that correct?

Ms Souldre: That is correct.

The Chair: I just wanted to be clear. Thank you very much for your presentation today. We appreciate your coming before the committee.

CECILIA BRANCH

The Chair: I call Cecilia Branch. Welcome. You have 10 minutes for your presentation.

Ms Branch: My name is Cecilia Branch and I would like to give you a brief statement. From the age of 16 until my retirement in 1987 I was a member of the Canadian national track and field team for the 100-metre hurdles. Between 1976 and 1980 I attended the University of Nevada, Las Vegas, on an athletic scholarship. I was selected to the Canadian Olympic team in 1980 and I was Canadian champion in 1985.

Since my 1987 retirement from active competition I have worked as a trainer, more or less a strength and conditioning consultant, with many athletes and teams, including the Ottawa Rough Riders. That is why they are winning. I am also completing my master's in sports psychology at the University of Ottawa.

My chiropractor, Dr Ken Dick of Ottawa, has explained to me that the suggested new law to regulate the practice of chiropractic does not include the right to diagnose extremity joint problems. I do not understand this at all because it is my experience that chiropractors are highly skilled and very effective in this area, more so than

any professionals I have consulted during a very long career in athletics.

I pulled a hamstring in my left leg in 1979. In case you do not know what a hamstring is—some people do not—it is the upper back of your leg muscle. During the next few years I received a lot of medical advice on what caused the problem. However, no one got to the bottom of it and I had continuing problems that were very frustrating and affected my career.

Then in 1986 I consulted Dr Ken Dick for an injury to my right leg. I also told him about the chronic problem with my left hamstring. He gave me a much more detailed examination and diagnosis than I had ever been given before. He explained how my hamstring problem is related to disturbed mechanics in my knee and pelvis and muscle imbalances in my leg. With a combination of manipulation, massage, interferential and other physical modalities, he completely cured my problem for the first time in seven years. It has been right ever since. Dr Dick has looked after my leg injuries, such as an ankle problem, which is Achilles' tendonitis, since that time and I have referred a number of other athletes to him and other chiropractors with good results.

I have found chiropractic diagnosis of extremity joint problems to be very thorough and of great help in my athletics career. I cannot imagine why a new law would prevent a chiropractor from providing this service.

Mr Beer: We have had a number of people relate personal experiences to us and one of the questions I have had is, when you have done this with your chiropractor and found this has worked well with you, have you discussed that with your own physician or with other medical doctors who have tried to deal with it, in terms of saying: "Look, I continued to have trouble. I went to the chiropractor, who found a way to resolve it. How come you didn't seem to be able to find the answer?" Do you have any sense in what you have gone through as to why that did not happen?

Ms Branch: Basically what happens is you go to many doctors to try to find out what your problem is and, being an athlete, you are very impatient and you want to get down to the crux of the problem and you want to get healed within four to six weeks or less. Therefore, if they cannot properly diagnose you—and I have been misdiagnosed by physicians, which is quite frustrating, and I have had such incredible success with my chiropractor, Dr Ken Dick, that I do not really like to go back to the physician and tell him that he was full of beans and did not properly diagnose me. No, you more or less move on to find the answer, because we do not have a lot of time to wait to heal. We want to get down to the real crux of the problem and get ready and on the track again. I never went back. I was misdiagnosed by a physician in sports medicine three times and strike three, to me, is you are out.

Mr Beer: That is why you are in sports.

Ms Branch: That is right.

The Chair: Thank you for your presentation.

1550

G. LAWRENCE NELMS

The Chair: I call Mr Larry Nelms. Welcome. You have 10 minutes for your presentation.

Mr Nelms: Thank you very much. I am a businessman working in Ottawa, obviously in the optical business, as you can see by the letterhead.

Thank you for affording me the opportunity to express my thoughts on the proposed Regulated Health Professions Act. I do not envy the task of the standing committee in rationalizing the needs and wants of all the vested interest groups which will appear before you. It is daunting, to say the least. Let me put into perspective the area of opticianry which I believe will shape the future of our industry.

It appears that this future hinges on precise definitions, which are presently lacking in the proposed act but are recommended by the Board of Ophthalmic Dispensers. The present board is recommending that "to dispense" will mean: (a) interpreting a prescription for, (b) evaluating or advising a person in respect of, or (c) preparing, providing, verifying, adapting, fitting or duplicating a device for sub-normal vision, a contact lens or eyeglasses. This definition encompasses all the duties and responsibilities which presently govern the action of opticians in the province today.

You have heard other representations from the Vision Council of Canada, which has suggested that a more liberal interpretation of the definition of "dispensing" be used, namely that the optician be responsible for the final verification and delivery of eyeglasses to persons over the age of 10 years. The optician would be responsible for all steps necessary in the delivery of contact lenses and eye wear to children under the age of 10.

Both groups purport to serve the public interest through a legislated act of Parliament. In reality though, the public is unaware of the protection afforded it now by the Board of Ophthalmic Dispensers because the board has failed to inform the public of its existence and of the powers it has over the industry to protect the public interest.

Its role to the public is passive rather than interactive and any use of its powers to maintain conformity with the present act is initiated by the use of the board inspectors or through action commenced by written complaint, usually lodged by a fellow optician. Thus, the powers of the board are well known within the industry, but the public is oblivious to its function. It is only through this indirect procedure that the public interest is protected.

Consumer complaints today are directed towards the supplier of service, the optician, and when they are unresolved, the prescribing physician, the ophthalmologist, becomes the arbiter. I know of no cases where a complaint was referred to the board for resolution. In this manner, the overall industry is seen as being entrusted with the protection of the public interest.

The position of the Vision Council of Canada appears to be based on economic practicality in which it recommends limited use of an optician to perform statutory duties. The membership of the VCC is drawn from the larger optical chains, which typically employ more than one optician per outlet. By reducing the numbers of qualified staff necessary

to operate a dispensary, the economic benefits are substantial. Our own firm has several such locations and whereas I presently employ five licensed opticians under current circumstances, I could easily reduce that number to two and increase my net profit by between 10% and 20%. The VCC is proposing a minimalist scenario allowing opticians to remain within the Regulated Health Professions Act, thereby ensuring some form of regulation to restrict practice.

The new college governing the practice of opticians would be impotent to regulate the in situ operations of opticians under the VCC's proposed definition. Thus, there are really only two alternatives your committee can adjudicate: either a college with all the necessary powers to firmly regulate the practice of opticians or else a completely deregulated delivery of eye care services in the province where the marketplace determines the protection level of the public interest. Half measures, ultimately, will not work.

The businessmen and businesswomen who constitute the optician side of the delivery of eyecare in our province are seeking a clear, unequivocal set of rules under which they can run their businesses. Whether your recommendation favours regulation or deregulation, we expect our government to make a decision so that we can get on with the rest of our lives. In the event that you follow the recommendations set out in the Board of Ophthalmic Dispensers' submission, I would suggest that provision be made to include a continual public awareness campaign so that the general public of the province know there is an authoritative industry watchdog there to address their concerns. I would also suggest that the annual renewal of an optician's licence to practise be predicated on achieving standards of continuing education.

If instead you prefer the recommendations of the VCC, I suggest you carry its position to its logical conclusion and institute a qualified—that is, contact lenses and children excluded—deregulation of our industry with the marketplace being the great equalizer. I am in favour of the former because I know the value of a well-educated and fully trained optician working in my business. The quality of my product would suffer at the hands of individuals who have not undergone formal education. My labour costs would go down, but my laboratory costs would certainly rise if I were to remain conscientious and truly satisfy my customers' needs.

Your decision will affect the thousands of lives of those who work in our profession and impact an industry which trades in the hundreds of millions of dollars annually. To think that all of this is hinged on a definition. I welcome your comments.

Mr J. Wilson: On page 3, you state that the new college would not be able to effectively regulate the operations of opticians under the VCC's proposed definition. I am going to give you an opportunity just to explain that a little further, if you would. It seems to me, just as a layperson, that the liability under the VCC's proposal still rests with the optician, the ultimate liability of whether the glasses are fully constructed and the customer is satisfied and the prescription has been properly interpreted. It seems to me the college still has control over opticians.

Mr Nelms: The college would have control over opticians, but I am looking at current circumstances whereby the regulation of opticians is governed by the Board of Ophthalmic Dispensers today, and in the province there is very little power, relatively speaking, that the board has over the day-to-day actions of opticians in Ottawa. The board inspectors come through here on an annual basis and it is usually once. Everybody in town knows the inspectors are here. Everybody sharpens up. That is not necessarily the way to govern an industry. I think the only alternative to what I term a half measure, where there is only a licence in the store, is to open it up completely. As a businessman, I can deal either way.

Mr J. Wilson: I am missing the point, though. You are saying under the current situation the policing now is fairly ineffective.

Mr Nelms: That is correct.

Mr J. Wilson: So I do not see how this would make it any less effective if it is fairly ineffective now.

Mr Nelms: Precisely so. In other words, are we trying to tighten up the industry through new legislation or maintain a status quo?

Mr J. Wilson: We would be trying to tighten up this particular industry if we had some evidence of cases of harm. Perhaps you would want to comment on that. We did have the board present some cases.

Mr Nelms: I think that Brent MacInnis appeared earlier before the committee, and I cannot cite any instances of harm.

Mr J. Wilson: I do not like tightening up just for the sake of tightening up.

Mr Nelms: Well, tightening up for the purpose of regulation so that, in reality, an unlicensed or an unregistered individual could not practise opticianry. At the moment it is very difficult for the board to police and patrol that. There is a fellow here in town who has been running a business for the last 14 years and he does not have a licence. We do not know how he gets away with it.

1600

Mr J. Wilson: Somebody should complain to the board.

Mr Nelms: Complaints have been lodged. To date, there has been no conclusive result simply because the board does not have the teeth to go after it. So either we have a regulated industry with teeth in the legislation, or we do not. What I am suggesting is that people in the industry can go either way. We are flexible, but what we expect are the rules. If the rules are wide open, let's go with it. If they are not, fine.

Mr J. Wilson: I appreciate your candour there. Thanks.

The Chair: I think you have articulated the different economic interests extremely well, and we appreciate your candour. Does the legislation as presented represent the status quo, tightening up or loosening up, from your point of view?

Mr Nelms: I think it is slightly less than the status quo because there is not an adequate definition of dispensing.

The Chair: If there is additional information that you think would be helpful, please feel free to communicate with us in writing, but we do appreciate your coming before the committee today.

JOHN COX

The Chair: John Cox, welcome to the committee. You have 10 minutes for your presentation.

Dr Cox: I am a dentist. I am a prosthodontist, a specialty of dentistry which is involved with basically crowns, bridges, dentures, implants; that aspect of dentistry. As a practising prosthodontist, I have a number of concerns regarding the proposed legislation as outlined in Bill 50, which would seem to expand the role of the denturists to allow them to provide removable partial dentures directly to the public. I am very concerned that the denturists are being placed in an untenable position whereby they will be allowed to construct removable partial dentures but not allowed to alter tooth structure in the mouth for the construction of that partial denture. In the construction of virtually all cast removable partial dentures, I feel, and I think the literature supports it, that preparation and alteration of the teeth is required. Also the denturist is ill-equipped to diagnose adequately the condition of the patient's oral cavity prior to denture construction.

Examples of that would include limited medical knowledge to screen for oral pathology such as cancer and limited equipment for assessment of oral cavity; what comes to mind is diagnostic equipment such as X-rays. They are not in a position to be able, with the current legislation, to assess periodontal disease adequately; that is, if you read the legislation as it is proposed, they are not allowed to probe for periodontal pockets or adequately assess the periodontal health of the supporting tissues. If dentists were not to do that, they would be in a position where there would be grounds for malpractice, not adequately having assessed the teeth. They are not in a position to assess adequately the occlusion or bite and, again, they are not able to alter tooth structure prior to partial denture construction.

I feel great concern in this area and that this can only lead to missed oral pathology or disease; missed decay in construction of partial dentures on teeth with decay present, since they do not have the diagnostic equipment to look for it; partial dentures constructed on teeth with gum disease through inadequate assessment; poor occlusion or bite and this in turn can lead to temporomandibular joint problems and, again, dentures constructed with no alteration of tooth structure, which from our standpoint is not a correct treatment.

The denturists have been arguing that price and quality of service are the real issues at stake. It would seem to me, given the limitations imposed on the denturists, that it is hard to imagine the quality provided would be better than that offered in a private dental office with full diagnostic equipment. While price is an important issue, at the present time there is no comprehensive data to suggest that present fees charged by denturists for a procedure that at the present time is unlicensed will be maintained. I feel the real issue in question is the appropriateness of the treatment which is

being offered by the denturist, who is able to offer only one service at the present time.

Perhaps an example of this might serve to illustrate my concern. Perhaps we can bring it a little closer to home if we imagine one of ourselves leaving this meeting and tripping and knocking out two front teeth. What is the procedure which is set in process? In the dental office the first consideration would centre around the possibilities of reimplanting the teeth. If they were retrieved clean and intact within perhaps 40 minutes of the injury, then they would be in a position that the teeth could be reimplanted and as such reused. This option would not be available to the denturist or perhaps not suggested. However, assume that the teeth were not retrievable and that we were in a position where we required some form of replacement. Both the denturist and the dentist would likely construct interim or temporary dentures, since these simple acrylic dentures can be quickly and inexpensively constructed, to replace missing teeth. Both offices could provide this service probably within a day in order to re-establish aesthetics and function.

Once healing had taken place, the denturist would be in a position to provide only one option. In terms of a final replacement for the missing teeth, this option would be a cast removable partial denture. This is really the item which is at question today. However, as outlined, there are very serious limitations imposed on the provision of this service, or to put it another way, the denturist is being asked to provide this service with one hand tied behind his back in terms of assessment and alteration of the teeth.

An equally important issue relates to the ability of the denturist to outline the options available for treatment. For the patient to make an informed decision, it is very important that he not only has the possible options presented but also the pros and cons of the different options. We feel that in this position the denturist may be somewhat limited in terms of his ability to discuss and present the options which are possible. There indeed is an ethical concern related to whether the denturist will refer a patient to a dentist, even if he can provide information on the different options.

Getting back to our example of the two missing front teeth, this has become, in our office anyway, a very complex diagnostic problem in light of the wide variety of options which are possible in the dental office. If the teeth adjacent to the space have no gum problems and have adequate bone support, then a conventional fixed bridge could be considered. This option might be more feasible in an older individual, where there are restorations or fillings on the adjacent teeth, since this option requires reduction of tooth structure for the teeth which will serve as abutments. In these days we see many younger individuals with fewer cavities in their mouths who would be reluctant to have adjacent teeth reduced to accommodate a fixed bridge. If there was sufficient space between the teeth, both upper and lower, and lack of grinding habits, then these days we could consider a very conservative option, that being a so-called Maryland or etched bonded bridge. This requires very limited reduction of the teeth but does still require some preparation to accommodate this appliance. However, this bridge has to be used very selectively and does

not work in all situations. Again, the diagnostic problem is there and we run into it every day.

Another option in this situation these days involves the use of osseointegrated titanium implants to replace missing tooth structure. Again, this requires a very careful assessment involving close interaction between both the oral surgeon who will be involved and the dentist who will be providing the final replacement. Again, we have a great deal of scientific data to suggest that this treatment option, which has now been followed for approximately 26 years in Sweden, is a viable option and yet another diagnostic consideration.

Another possible option of course is a removable partial denture, as discussed. Again, it gets us back to our chief concern, I think, in terms of today's issue. This option, which is also available in the dentist's office, has wider scope for success if there is adequate preparation of the teeth. It does not necessarily have to involve extensive preparation, but it is very common to see a patient come with an old, broken-down filling which should be replaced prior to construction of a partial denture. If there are large fillings, then sometimes a crown is indicated, and there are a variety of different partial dentures, right down to precision partial dentures, that require construction of crowns prior to construction of the partial denture. At the very least, small recesses or rests should be provided on the surfaces of the teeth, since these rests control all of the forces which are transmitted to the patient's teeth by the partial denture.

The point of my example is only to illustrate that if we were in the position described, I feel it is mandatory that the options possible be outlined for a patient to make an informed decision as to which option he would like to see take place in his mouth. The extension of the role of the dentist into the direct construction of partial dentures once again fragments dental service. It makes it very much more unlikely that the patient is going to be in a position to make an informed decision and, I think, makes it virtually impossible to receive a high quality partial denture, given the limitations that are imposed. Partial denture service should remain a prescribed service in the same manner that a hearing aid or a vision device is a prescribed service.

Thank you very much for the opportunity of presenting the brief. I would be happy to try to answer any questions that might be related to my presentation. I brought along slides to illustrate this, but unfortunately in our discussions with the people at the other end we did not quite get a projector.

The Chair: Just for your information, the committee did receive slides and copies of X-rays or photographs showing some of the things that you talked about, so not to worry that we did not get a chance to look at your slides. We appreciate hearing from you and if there is additional information that you feel would be helpful, please feel free to communicate with us in writing.

The standing committee on social development stands adjourned until 10 o'clock tomorrow morning, in committee room 2, legislative building.

The committee adjourned at 1612.

CONTENTS

Monday 26 August 1991

Regulated Health Professions Act, 1991, and companion legislation / Loi de 1991 sur les professions de la santé réglementées et les projets de loi qui l'accompagnent	S-627
Allergy and Environmental Health Association, Ottawa branch	S-627
Ontario Naturopathic Association	S-629
Jenny Thomas	S-631
Jack Gryfe	S-633
Association of Concerned Citizens for Preventive Medicine	S-634
Matthew Yeager	S-637
Ontario Psychiatric Survivors' Alliance of Ottawa-Carleton	S-638
Andrée Durieux-Smith	S-641
Bereaved Families of Ontario, Ottawa-Carleton branch	S-642
Attendant Care Action Coalition of Ottawa-Carleton	S-643
Jay McSpaden	S-644
Cindy Harrison	S-646
Coalition of Ontario Midwifery and Birth Schools	S-647
Ontario Medical Association	S-651
Ontario Medical Association, section of ophthalmology	S-654
Ontario Chief Psychologists Association, eastern region	S-656
Ottawa Academy of Psychology	S-658
Canadian Society of Hospital Pharmacists, Ontario branch	S-660
Janise Johnson	S-662
Community Health Nurses' Interest Group	S-664
Cecilia Branch	S-665
G. Lawrence Nelms	S-666
John Cox	S-668

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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Under the new system, the sequence of numbering started in January 1991 will end with the final House and committee sittings of the present First Session. A new sequence will begin on the opening day of the Second Session, and each succeeding session, which will be issue 1 and begin with page 1. Committee reports likewise will be numbered from the first sitting of each committee in a parliamentary session.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday August 27 1991

The committee met at 1001 in committee room 2.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

ONTARIO SOCIETY OF OCCUPATIONAL THERAPISTS

The Chair: Good morning. I would like to welcome everyone and call first the Ontario Society of Occupational Therapists.

Mrs Cameron: My name is Debbie Cameron and I am the president of the Ontario Society of Occupational Therapists. With me is Dr Helene Polatajko, past president of the Ontario society, and Christie Brenchley, our executive director.

I would like to begin today by expressing our appreciation for the opportunity to appear before you. I hope that by the end of this presentation you will have gained a better understanding of occupational therapy, our society and its position on the proposed Regulated Health Professions Act.

The Ontario Society of Occupational Therapists, or OSOT, as I will refer to it, is a professional association of occupational therapists eligible to practise in the province of Ontario. Incorporated under letters patent in 1921, OSOT was the first professional organization of occupational therapists in Canada. Today the society works on behalf of Ontario's 2,300 therapists to address and promote issues relating to education, government affairs, professional issues and public relations.

Occupational therapy as a profession developed in Canada after the First World War. Working with veterans, therapists demonstrated the positive and important contributions that the application of purposeful and meaningful activity made in the rehabilitation of individuals with physical and emotional dysfunction.

Occupational therapy addresses problems in functional or adaptive behaviour in persons whose occupational performance—self-care, productivity and leisure skills—is impaired or likely to be impaired by illness or injury, emotional disorder, developmental disorder, social disadvantage or the aging process. The purpose of intervention is to prevent disability and to promote, maintain or restore occupational performance, health and wellbeing.

Because problems in functional or adaptive behaviour can occur with anyone, OTs work with a diversity of client populations. This brings the therapists in contact with a broad cross-section of Ontario's population bridging all age groups, social sectors and cultural diversities. The occupational therapist may be involved in providing direct treatment, mediator training, consultation or research.

Ontario's OTs work in a wide variety of employment settings: hospitals, schools, nursing homes, home health agencies, developmental centres, rehabilitation centres, community mental health facilities, sheltered workshops, private practice and the workplace.

With a philosophical commitment to interdisciplinary teamwork, most OTs work as integral members of treatment teams with physicians, nurses, physiotherapists, community workers, etc. Trends towards community-based and accessible health services have placed increasing demands on occupational therapists whose expertise lies in facilitating the personal independence and functional performance required for successful community living.

In summary, if you, a family member or a friend knows a child with a physical disability, a teenager with a head injury or perhaps a spinal cord injury, a young adult who is mentally ill, a middle-aged acquaintance with multiple sclerosis or an older person with Alzheimer's, then likely an occupational therapist has been involved at some point in their rehabilitation process.

The Ontario Society of Occupational Therapists registers its clear support of the Regulated Health Professions Act. Believe it or not, we have been working on legislation for longer than this government has. For nearly 25 years, occupational therapists in Ontario have sought legislated regulation in an effort to ensure the quality of OT services provided to Ontario residents. We believed so strongly in this concept of regulation that we instituted a voluntary regulatory body, the Ontario College of Occupational Therapists, in 1984.

RHPA will enhance the public protection while providing a framework for a more equitable system which respects the autonomy of individual professions. The quality assurance requirements are innovative and will prove challenging and exciting in their implementation.

Clearly, we are supportive of the RHPA. Of course, we would not be here today if we did not feel that some minor modifications needed to be made. Our purpose here today is to point out our concerns.

With respect to Bill 43, the omnibus act, we have two concerns. Our most serious concern is with the controlled act, paragraph 26(2)1 of the RHPA. This one I am sure you are all very familiar with. It reads, in part, "Communicating to the individual or his or her personal representative a conclusion identifying a disease, disorder or dysfunction."

As occupational therapists, we would concur that the identification of disease is an act which we are not qualified to perform. However, the identification and communication of disorders and dysfunctions is something that OTs perform on a regular basis. In fact, our scope-of-practice statement outlines our obligation to assess function and therefore to identify dysfunction.

We are very concerned that this controlled act will limit current occupational therapy practice. We routinely formulate and communicate conclusions about the causes of symptoms within our scope of practice.

For example, when a client suffers an injury to his spinal cord, perhaps as the result of a diving accident, the physician would make a diagnosis identifying the level in the spinal cord where the injury occurred and the extent of damage. Following this, the occupational therapist would be involved in assessing what the client could still do for himself on a functional level. Due to the amount of swelling around the injury or the time elapsed since the accident, the client's diagnostic level and his functional level might differ. However, to the client and his family, accurate assessment of his remaining skills would be vital. We feel that it is equally vital that clients are able to obtain the results of these assessments from the professional who carried them out. As the act is currently written, the results of this assessment could not be shared directly with the client or his family. This "communicating" would have to be undertaken by a physician.

We understand that this act is not intended to limit current practice, but wording such as "communicating," "disorder" and "dysfunction" are sufficiently vague as to arouse serious concerns among therapists. The controlled act paragraph 26(2)1 as it is currently written could interfere with professionals working as a team by placing those professions allotted this controlled act in the role of gatekeeper of information to clients and families. The economic implications of this to the public purse must also be considered.

1010

Our proposed amendment to solve this problem would be to add a subsection to section 26 which would state that people regulated under the provisions of this act will not be deemed to be in contravention of paragraph 26(2)1 when performing assessments that are within the scope of their practice, including the formulation of assessment conclusions and the communication of such to clients.

Our second concern with Bill 43 is with subsection 30(1), which restricts use of the title "doctor." We understand the intention of this section is to reduce public confusion. However, we feel that this title restriction has several other implications that should be considered.

People are entitled to know the qualifications of the therapist who is treating them and should be able to easily identify and seek out a therapist with higher educational qualifications if that is their desire. The OSOT feels that individuals who have earned their PhD have the right to use the title "doctor." To restrict the use of this title goes against standard practice in other provinces and countries.

The fact that RHPA has legislated that certain health care professionals can use the title "doctor" and not others

is discriminatory, inconsistent and lacks justification. The title should apply to all those who have earned it, regardless of discipline. Given the current lack of researchers and educators, the health care system should be doing all that it can to encourage individuals to obtain higher education. These individuals are the ones with the skills to ensure through research that the service provided to the public is of the highest possible quality.

Our recommendation would be to allow the use of the title "doctor" only with the use of the professional designation. In other words, an occupational therapist with a PhD would be known as a doctor of occupational therapy.

With respect to the Occupational Therapy Act, or Bill 58, we also have two concerns. Subsection 14(1) of the Occupational Therapy Act, entitled "Restricted Titles," concerns us. The subsection currently reads, "No person other than a member shall use the title 'occupational therapist,' a variation or abbreviation or an equivalent in another language in the course of providing or offering to provide, in Ontario, health care to individuals."

We are uncomfortable with the phrase that limits title protection to the area of health care. In our profession particularly, many members work in areas that might be considered to be outside the health care field. For example, therapists work in school boards, industrial settings and insurance companies. In these settings the title "occupational therapist" would not be protected. Therefore, a member of the public may be misled about the qualifications of an individual practising outside health care. Only when dealing with an occupational therapist in the field of health care could a client be assured of obtaining service from a regulated professional.

We would suggest that simply dropping the last phrase, "in the course of providing or offering to provide, in Ontario, health care to individuals," would solve the problem and offer the public the maximum protection possible.

Our second concern with Bill 58 is in subsection 14(2), which deals with representation of qualifications. Currently this section states, "No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as an occupational therapist or in a specialty of occupational therapy."

The wording in this subsection is not strong enough and places no limitation on unqualified individuals who wish to mislead the public with the use of various descriptors or descriptive phrases. For example, an unqualified person could be claiming to be providing occupational services within a hospital or community clinic. Clients could be misled by the use of such a descriptor into believing they were receiving service from an occupational therapist.

The Ontario Society of Occupational Therapists feels that the public would be better served by a stronger clause which would add to the above section the phrase, "or use any name, title or description implying or calculated to lead people to infer that the person is qualified or recognized by law as a member."

In conclusion, the Ontario Society of Occupational Therapists is very supportive of the Regulated Health Professions Act. However, we feel that the legislation could be strengthened by introducing the minor amendments outlined

above. As is clear to us from discussions with many other groups and must be clear to you from previous presentations you have already heard, we are not alone in these concerns.

We appreciate this opportunity to present our views and look forward to continuing to work with all concerned individuals in the future. We welcome the opportunity to answer questions at this time.

The Chair: Thank you for a very thoughtful presentation.

Mr Owens: When a patient comes to see you, he presumably comes to you with a chart, and with a diagnosis listed on the chart.

Mrs Cameron: Not necessarily. It depends on the setting in which you are working.

Mr Owens: Right. If you are working in a hospital setting, for instance.

Mrs Cameron: Likely there would be a medical chart, yes, with the diagnosis listed.

Mr Owens: I guess I am struggling with what type of diagnosing you would in fact be doing. When you talk about the oedema on a patient's hand, is that not just a symptom of an existing diagnosis where you would simply be performing an assessment rather than diagnosing why the oedema is there?

Mrs Cameron: Yes. That is the problem that we struggled with in trying to address this whole question. I guess in looking at it, though, we feel that when it is expanded to say "disorder and dysfunction," although we could not diagnose with a medical diagnosis, we often might label a dysfunction. It is not always clear to us in all cases that a dysfunction could be directly attributable to a diagnosis that has already been made by a doctor.

For example, if you were looking at a learning disabled population, where they may be having troubles in school, you may be called in to assess a child. He may not have been given a medical diagnosis, so you may come up with a label of a type of dysfunction without its having been identified clearly with a medical diagnosis. This is the area where we have trouble with this phrasing. In looking at it and in talking with the ministry people, their intention is not to limit that kind of thing that we do, but we just are not comfortable that the language at this point is clear enough to allow us to continue to do what we normally do.

Mr Beer: Thank you for your presentation. In the same area, around the communication, if the word "dysfunction" were removed from that, how far would that go in making you feel warmer and more comfortable?

Mrs Cameron: That was certainly one of the possible options that we looked at suggesting as we went through it. I think part of our discomfort was that none of those terms are presently defined in the legislation, so we were unsure of the intent in putting "dysfunction" in there and wondered if there were some areas of practice, psychiatry, etc., where there may be a differing definition to the one that we might use.

Mr Beer: I will ask a question through the parliamentary assistant then. In the example on page 6, at the bottom of the page, where it says, "For example, when a client

suffers an injury to his spinal cord," and then the physician makes a diagnosis—in terms of what was described and what follows, I would have thought that would be perfectly legitimate for the occupational therapist to do and that it could not be construed as being in any way communicating a diagnosis or leading to a conclusion, or however the wording goes.

Mr Wessenger: Yes, I would agree with that. In our interpretation we do not see that in any way conveying a diagnosis.

Mrs Cameron: I would like just to add to that. Our reason for using that particular example is that in that area of spinal cord injury, the medical diagnosis might be that the client has suffered an injury at a particular level in the spinal cord. When we would look at it functionally, we might find that due to an incomplete lesion or other factors in the healing process, the client actually functions at a much higher functional level than what might be indicated by a strict medical diagnosis. Therefore, the functional level and the diagnostic level would actually differ. I think that was our reason for using that particular example.

Mr Beer: So the concern is, are you communicating an effective dysfunction of some sort?

Mr J. Wilson: You mentioned in your brief the use of the title "doctor." I am certainly supportive of PhDs being able to use "doctor," but in a case of, for instance, occupational therapy, my understanding is that it is a four-year bachelor of science in OT, that there is no such thing as a doctor in occupational therapy. Is there a doctorate?

1020

Dr Polatajko: There are degree programs in the United States and in South Africa that offer PhDs specifically in occupational therapy. However, most of us who have PhDs have a PhD in a field that adds to what we practise in. For example, I practise in paediatric psychiatry. My PhD is in special education. My PhD deals with learning disabilities, which are the kinds of kids I deal with. Consequently, I feel I am more able to deal with a learning-disabled child as a PhD than I would be as a BScOT.

Mr J. Wilson: I am glad I asked the question. I had no idea the States was offering it.

Dr Polatajko: I think also one thing that needs to be noted is that having PhDs in our profession, and indeed in a lot of the rehab professions, is a fairly new thing, just as accountability is a fairly new thing. As we get more PhDs, it will become a better thing; accountability will become better. When I got my PhD in 1982, I was the fourth in Canada. Right now there are about 25 of us, and right now there are another 20 or 30 who are in the process of obtaining their PhDs. Many of those are in Ontario because Ontario holds most of the therapists in the country.

Ms Haec: Do you have a breakdown of where the majority of your OTs are working? Are they strictly in a hospital setting or are they in rehabilitative education?

Mrs Brenchley: The Ontario Society of Occupational Therapists represents approximately 1,250 to 2,300 OTs in Ontario. Of our membership, approximately half work in institutional facilities, and with growing demands

for community-based and accessible services, we are certainly seeing an increasing number of therapists working in community-based settings, school systems, industry, etc.

The Chair: Thank you very much for your presentation. We appreciate your appearing before the committee this morning. If you have additional information over the course of our deliberations that you think might be helpful or of interest to committee members, I hope you will feel free to communicate with us in writing through our clerk.

ONTARIO COLLEGE OF OCCUPATIONAL THERAPISTS

The Chair: I would like to call next the Ontario College of Occupational Therapists.

Ms Polgar: Thank you. I am Jan Polgar. I am the chairperson of the council of the Ontario College of Occupational Therapists. With me are Liz Verlaan, the registrar of the college of occupational therapists, and Alice Kusznir, the vice-chairman of the council of the Ontario College of Occupational Therapists.

I would like to direct your attention to page 4 of our document. The Ontario College of Occupational Therapists, or OCOT, welcomes the opportunity to present our views on the Regulated Health Professions Act to the standing committee on social development. While we know that most of our concerns have already been raised, we trust that our words will add strength to those views that have been previously presented.

As Debbie Cameron mentioned, OCOT was established as a bylaw of the Ontario Society of Occupational Therapists in 1984. The purpose of OCOT is twofold: first, it provides a means of regulation of those occupational therapists who choose to become members; and second, it has acted on behalf of OSOT and all 2,300 practising occupational therapists in Ontario on matters that are related to self-regulation of our profession since we have come into being. The college's formation and our development are definitive examples of the commitment of occupational therapists to the protection of the public through a self-regulatory model.

OCOT has formed a number of committees. These include a registration committee and complaints, discipline and appeals committees in order to achieve self-regulation. We have a proportion of lay members on each of our committees. In addition, we have investigated the issues of standards of practice, continuing competence and quality assurance in anticipation of their requirement through the legislation.

OCOT is very enthusiastic about the proposed legislation. We strongly support the purposes of increased public accountability, protection and consumer choice. We find that the requirement for the development of a quality assurance program is very exciting. We feel that quality assurance should be something the professional understands as being important to the development of practice and not as an interference with daily work. We are challenged by the impact which this requirement will have on our research and subsequently the level of care which we provide to our patients.

While we believe that RHPA is important and we definitely support its passage in the Legislature, we have concerns about three sections of the act which we feel will have an adverse effect on public protection and public interest. These sections are paragraph 26(2)1 of Bill 43 and subsections 14(1) and 14(2) of Bill 58, the Occupational Therapy Act. I address first paragraph 26(2)1, Bill 43, about which I know you have heard a lot.

While neither diagnosis nor assessment is defined in the act, we feel that paragraph 26(2)1 implicitly refers to diagnosis. This controlled act does not appear in the Occupational Therapy Act, and it limits those professionals who are able to in part communicate "a conclusion which identifies a disease, disorder or dysfunction as the cause of symptoms."

We believe the public interest will not be served by this section as it is currently written because:

1. Occupational therapists will not be able to communicate the results of their assessment if these results identify the cause of symptoms. So if we identify a dysfunction and relate that dysfunction to the symptoms that the person is having, we will not be able to make that comment.

2. The patient's physician will be required to communicate those assessment results, which will cause delay in the system, potential misunderstanding—because our idea of the patient is different from a physician's idea of the patient—and also anxiety on the part of patients as they wait for the results.

3. Patient education that relates to how their symptoms or how their disease or disorder causes their symptoms will be restricted.

4. The college's complaints and disciplines process may be encumbered as patients make complaints against actions which are contrary to the letter of the law but not the intent of the controlled act.

5. Health care costs will rise as patients must see another practitioner in order to hear assessment results.

Daily, occupational therapists perform tasks as part of their practice which may be interpreted as being in contravention of this section. A common example is in the evaluation of perceptual function in a patient who has sustained a cerebral vascular accident. Right-left discrimination is a perceptual dysfunction which is identified by occupational therapists through testing and observation of task performance. Upon identification of this dysfunction, the occupational therapist communicates to the patient how it causes problems relating to dressing or other daily activities. We see that this type of communication will be limited.

Another significant component of our practice is patient education. The occupational therapist may discuss, for example, how the disease of multiple sclerosis causes the symptoms of fatigue. This education is vital to the patient's ability to cope with and compensate for her medical condition. Again, we see that this type of education may be limited by the language of this particular controlled act.

We understand how this controlled act came to be and that it is an attempt, essentially, to operationally define the thought process that is involved in determining a diagnosis. We understand how difficult it is to capture a person's

thought process in words. However, we find that the language of this section does not adequately do so and results in the restriction of information that the patient may learn from professionals not granted this controlled act.

We do not want to make a medical diagnosis. However, we do want to communicate the results of our assessments and to provide useful patient education, both activities which we see may be restricted by this section.

We recommend the addition of a subsection to section 26 which essentially would indicate that people would not be in contravention of paragraph 26(2)1 when they are in the process of communicating the results of their assessment to their patients. We believe this amendment would be satisfactory, since it both provides protection to the public from those individuals who are not competent or qualified to make a medical diagnosis and does not limit the responsibility of individuals, regulated health care professionals, to communicate results of their assessments.

1030

In subsection 14(1) of Bill 58, the title "occupational therapy" is restricted in terms of the provision of or offering to provide health care only. We believe that the use of the words "health care" results in inadequate protection to the public. As you have already heard, occupational therapy is a broad type of profession and we do work in situations which may not be considered to be health care or provide activities that may not be considered to be health care.

For example, we do vocational testing in industry, in schools, where we may be assisting an individual to determine a job choice. In this instance the title "occupational therapist" would not be protected, nor would there be regulation of an occupational therapist in that area. So we feel that consumers are not assured that the person providing their services has appropriate qualifications.

We recommend that the section be amended to read, "No person other than a member shall use the title 'occupational therapist,' a variation, abbreviation or an equivalent in another language."

Finally, subsection 14(2) of the bill, we believe, does not provide sufficient protection to the public from unqualified individuals who hold themselves out to be occupational therapists. This section does not limit specifically the use of names, descriptions or titles which would indicate that the person is qualified to be a member of the Ontario College of Occupational Therapists. We believe that minimally this section should contain some statements that make it more specific and we recommend the following wording:

"No person other than a member may take or use any name, title, description, variation or abbreviation in another language implying or calculated to lead people to infer that the person is qualified or recognized by law as a member of the College of Occupational Therapists of Ontario."

This rewording is consistent with the recommendation of the Health Professions Legislation Review. We agree with their recommendation and recognize it as one which will provide greater public protection.

In summary, OCOT is firmly behind both the intent and the goals of the proposed legislation. However, we feel

that certain sections of it limit the potential of the act to meet its objectives. We commend the government of Ontario for the open consultation which we have been involved in for the last nine years and we anticipate that this consultation will continue as the legislation evolves and grows. We appreciate the opportunity to express our views to this committee and we are confident that the committee will improve on the legislation as drafted to address the problems we have raised.

Mr Beer: When you suggest an addition to paragraph 26(2)1, how do you distinguish between an assessment and a diagnosis when you say that you want to be able to do an assessment? Could you give us an example of what that would mean and how we would relate what you intend to do if we were to put that in with not doing a diagnosis?

Ms Polgar: One of the areas I see could potentially cause a lot of problem is the area I have mentioned, which is looking at perceptual disorders. We do that with a wide variety of clients who have a neurological problem. For certain children, again with learning disabilities, we do a series of standardized tests and we may identify the child as being apraxic or dyspraxic through our assessment.

Mr Beer: Let me just stop you there. When you say you would determine through your assessment that the child was dyspraxic, for example, when you make that determination, what is the difference between saying, "My assessment led me to that conclusion," or, "I made a diagnosis"?

Ms Verlaan: I think if I could just add to that and complement what Debbie Cameron was talking about earlier, we really see it as a continuum, because you have symptoms and then you have disorder and dysfunction and then you have disease. If you see that continuum, there is a cause between the symptoms and the dysfunction, so you get a combination of symptoms and you can analyse a dysfunction. As soon as you use your own intellectual capacity to place some kind of judgement on those symptoms, you have made an assessment.

A step further is the diagnosis, which tends to be more in relation to disease. I know in psychiatry they evaluate disorder and dysfunction and call it by those terms, but generally medical diagnoses are diseases. What we are really saying is that an occupational therapist or any number of these other paraprofessionals place some kind of judgement on symptoms and we want to make sure that those judgements are accurate. Is that reasonable?

Mr Beer: Yes, thank you.

Mr Owens: My question is through the parliamentary assistant to ministry staff. How did the review look at the OTs with respect to their function as it appears as part of a diagnostic team approach? Perhaps not so much in the health care setting, but clearly in the school setting it appears you have more of a free hand, if I am hearing you correctly, with respect to your assessments and your conclusions. How did the review look at these folks in terms of looking at the ideology of a disorder or dysfunction and how these people would function within this legislation?

Mr Wessinger: I will have staff answer that question.

Ms Bohnen: The review thought that occupational therapists are qualified to and employed to assess function and lack of function and that they do not diagnose in the sense that I think the committee has heard elaborated upon, especially yesterday in the Ontario Medical Association presentation. If you take a look at the scope of practice of occupational therapy in the bill, which is identical to what the review recommended, it speaks in terms of the assessment of function and adaptive behaviour. The review thought there was a gulf or a divide between that and the kind of diagnosis that it was necessary to restrict to groups like physicians.

Mr Owens: So was it merely a question of semantics? If you are looking at function, if it is not functional then it is dysfunctional and that is why we have this problem or perceived problem?

Ms Bohnen: I think that this profession's issue is yes, one of their lack of comfort that on the existing language of the controlled act they will not be able to continue what they do even though the review and the government say: "Yes, you will be able to continue what you do. What you do is appropriate. You are qualified to do it." Their diagnosis issue is lack of comfort with what the legislation currently says. I do not mean to demean it by saying it is a semantic issue, but it is.

Mr Cordiano: My question has been answered, but I just wanted to clarify it further. In trying to give some more comfort to this group, we would simply say that what they do is not really a diagnosis of sorts, it is more of an assessment, if you will.

Ms Bohnen: I think that is exactly what the government has said, that what you do is provide an assessment. It is clearly set out in the scope of practice statement. No profession, no government representative, has ever said: "Occupational therapists have a tendency to overstep themselves. We don't want them doing such-and-such." Everybody agrees they are qualified to perform assessments and that is what the legislation permits them to continue to do.

1040

Mr Cordiano: Legally you would be looking at assessments in their realm or their scope of practice rather than crossing the line into what you might consider a diagnosis. It is a legal question basically.

Ms Bohnen: They do not wish to cross the line and to provide medical diagnoses, and the legislation would clearly discourage them from doing that.

The Chair: Thank you for your presentation before the committee today. We appreciate your coming forward and I know that you are aware that you can communicate with the committee in writing at any time during our deliberations.

CANADIAN ASSOCIATION OF OCCUPATIONAL THERAPISTS

The Chair: I will call next the Canadian Association of Occupational Therapists.

Mrs McGarry: My name is Jacqueline McGarry and I am the president of the Canadian Association of

Occupational Therapists. With me is Anne Strickland, who is our executive director.

I am not going to read through our brief. You have received a brief from us which outlines our concerns about the proposed legislation. I would like very much to thank you for this opportunity. We recognize very well that health care is a provincial matter and we appreciate your willingness to allow us to raise our concerns regarding this proposed legislation.

Our view will of course be from a national perspective. We have close communications with all the occupational therapy associations within all of the provinces. We meet as a group and we are very familiar with both their legislation and their practice. We support the Ontario society and the Ontario college position, and you will see in our brief that our recommendations are very similar to theirs.

One of the things I could alert you to is that we represent more than 5,000 members across the country, all of whom, with the exception of Ontario, are regulated in some way. It is significant because almost 46%, in fact probably this year more than 46%, of our members live and work in Ontario, so that half our membership is not regulated even though every other province is.

I should like to draw your attention to a data sheet at the back of the brief. You were asking about the division of our members and we have last year's data sheet for you there. Unfortunately, it does not break down Ontario per se, but it breaks down our membership throughout the country.

We are in essence supportive of this legislation but, from a national perspective, are concerned with the way in which the proposed legislation might impinge upon our client-centred practice. As a national body, there are many roles that we undertake, one of which is to set standards for the education of occupational therapists. Each of the 12 programs, five of which are in Ontario, subscribe to the standards that we set and are accredited by us.

I should also alert you to the fact that the Canadian Council of Health Facilities Accreditation has used many of our standards as its standards, so that hospital departments accredited by the Canadian association are in a good position to be accredited by the Canadian Council of Health Facilities Accreditation.

Within our programs, we try not to define the method by which they teach the students nor the content of the curriculum. But there is a basic curriculum, and in that the issue of how we practise is taught. The way we teach our students is primarily all within this book, which the Chairman has a copy of. It is more than 10 years of work. It is the guidelines for the client-centred practice of occupational therapy in Canada. It is because all programs and all occupational therapists in Canada work from this that we are concerned with some of the aspects of the proposed legislation.

One of our concerns is with the fact that there is no definition that I can see that clearly says what you mean by diagnosis. For me, diagnosis is usually a medical diagnosis. I would like it clearly spelled out that we are looking at a medical diagnosis. Occupational therapists often contribute to that diagnosis by contributing and collaborating with

the doctor in terms of the results of their assessments. What we mean by assessment is very clearly defined and outlined within this book, if that was your question, Mr Beer.

We use many ways of assessing, some of them standardized, some of them personal skills, some of them a review of the family, all sorts of ways that we do assessment. Our concern is not that we want to get caught up in words, but that it really is not clearly defined. We would ask you to review some of the suggestions made by the Ontario college in looking at that.

One of the things we look for is that our members be able to move across the country easily. Our fear is that the proposed legislation will inhibit therapists from other provinces from practising, according to this, within Ontario, primarily because of confusion around the area of assessment and diagnosis.

You will see from your brief that we have quoted to you the province of Alberta's wording, and also the province of Manitoba's. Again, they are not defining that word "diagnosis," as much as we contribute to diagnosis. I can recall an occupational therapist alerting a doctor to the fact that a child had muscular dystrophy—because her functional assessment demonstrated that. He had gone off looking at mental retardation and delayed development. It was the functional assessment contributed by the occupational therapist that alerted him to the issue of muscular dystrophy. So we contribute to medical diagnosis, but we have no scope of practice that says that we should do that.

Because of the client-centred focus of our practice, where the therapeutic relationship is essential to how we practise, we cannot practise without discussing working with the client. We set our goals with the client. We are looking for motivation from the client to reach these goals. It is that communication area of diagnostic results and assessment results that we are concerned will inhibit our practice.

It is not that we are not trusting. It is that we know people get hooked up with wording. We would ask you to look very carefully at that. Because without the collaboration of the client, without being able to discuss the strengths and weaknesses, without being able to discuss the actual programming with the client, our practice is severely limited. I am sure Mrs Caplan will allow you to review the guidelines we have given, which will outline that very clearly. I would like to turn over to Mrs Strickland.

Mrs Strickland: I will just carry on, if I may, on the other issues we have identified, as have our counterparts. On the restriction of the title "doctor," we are coming at it from a national perspective, thinking in terms of visiting professors who might be coming to teach occupational therapy from either out of country or from another province and of their ability to use the title "doctor." We feel the restriction on the title "doctor" really does not reduce the danger to clients of non-physicians who imply that they may have the qualifications.

1050

I would just like to share with you very briefly a recent example that a member in Ontario brought to our attention. It involved a chiropractor who had signed an assistive

devices program form as if he were a medical physician and discussed on the phone with that same member the client's epilepsy, again as if he were a physician. It was only after the fact that the member did find out that the person was indeed a chiropractor rather than a physician, and it was a little disconcerting to her.

CAOT believes that this provision of the act is restrictive and unfair to those who have studied and earned the right to call themselves doctor. In Manitoba, Alberta and Quebec there is absolutely no restriction on the title "doctor." CAOT believes that those who have earned it should be allowed to use it. However, we are concerned with the common practice of using the word "doctor." We suggest that people who have earned the title use it with their professional designation, that is, doctor of occupational therapy, and that they be required to do so. The only exception we would suggest would be the physicians, the medical doctors, because it is common practice in Canada to call a physician doctor without anything else to it.

In terms of restrictive titles, subsection 14(1), as with the other two presentations, we are concerned about the qualifier in the course of providing or offering to provide health care in Ontario. From our statistics and from the statistics in OSOT, you understand that we do practise in other areas outside of the health care field. We really feel very strongly that the public should be protected for occupational therapists who act in all areas of practice.

Mrs McGarry: You will notice on the data sheet that more than 10% I think it is—and that is growing every year—practise outside of the institution.

Mrs Strickland: Alberta, Quebec, Nova Scotia and New Brunswick do not limit the practice of occupational therapy to health care at all. In terms of presentations of qualifications, the concern is that the wording is not strong enough to protect the public from those who do not actually state that they are not occupational therapists, but who do imply that they are. This can occur in settings when an activity or a modality is used as diversion, and/or where there is a shortage of professional staff. Both of these situations occur in Ontario. They occur throughout the country. They occur mainly in chronic care institutions and in nursing homes. That is where this tends to happen.

The province of Manitoba has a holding-out clause similar to the one recommended by OSOT and OCOT. Quebec amended its extensive use of title in March 1989 to include the words "leads to the belief that he is an occupational therapist." The Quebec experience is still not strong enough, they feel. The interprofessional council is discussing with the provincial government the possibility of changing the act once again to make this part of its act stronger. We agree with the recommendations of OCOT and OSOT on this particular item.

Mrs McGarry: One of the reasons we are asking that to be made stronger is that we believe it will need to be reopened if we look at the experience of our other provinces who have that in their legislation.

Mrs Strickland: In summary, the CAOT is the national professional organization of 5,000 occupational therapists, 46% of whom work and live in Ontario. Ten

per cent of our members work in settings outside of the health care system. We believe that all therapists in Ontario should be regulated under this act. Our concerns are for portability of credentials from one province to another. It must not be easier for an occupational therapist in Canada to go south of the border and practise in the United States than it is to move from one province to another, and we hope that will be maintained. We must keep educated and qualified therapists in Ontario. This is a particular concern right now because there is a shortage of therapists in North America and they tend to be quite mobile and move around.

We have made recommendations or we have supported the recommendations made by OSOT and OCOT. We strongly believe that these changes will result in clarity of the interpretation of the act for the protection of the consumer.

In closing, I would like to thank you for giving us this opportunity to submit this brief. We realize we are the third in the stream of occupational therapists coming forth to address these concerns and I really want to thank you for listening to us and giving us this opportunity. We would be glad to answer any questions.

Mr J. Wilson: Thank you for your presentation. As a national organization, I think it is very useful to hear your perspective. I was particularly curious about your statement that you thought perhaps the proposed wording of the scope of practice statement might inhibit OTs from being able to practise in other provinces and from having the freedom to move within Canada. First, I ask you to expand on those comments. Second, would not the various provincial colleges of OT simply look at academic credentials?

Mrs McGarry: At the present time the entry level to practise in Canada is with an undergraduate degree from an accredited university, with a fieldwork placement of 1,200 hours, and with successful passing of the national COT examination. That becomes your entry to practise and gives you eligibility for membership in the national association. Many of the provinces' regulatory bodies use those criteria. They do not itemize them and they do not put them into their legislation, as membership is essential. But they use the criteria. In that way we are looking at ensuring the consistency of practice across Canada. One of our concerns is that Canadian consumers in Prince Edward Island should have the same access to the same qualified therapists as those in Ontario, BC and Alberta. In that sense, it is a standard, it is a guideline.

Mr J. Wilson: And you feel that our proposed scope of practice is too much of a variation on what other provinces are doing?

Mrs McGarry: I was referring there to the issue of the possible dispute between diagnosis and assessment, what it is, what it means, etc. What the association would not want to happen is for a therapist who had been practising in Alberta or British Columbia to come to Ontario and, because of the legislation, not be able to communicate with a client, not be able to follow through the kind of practice. That is our concern: that we want to maintain the portability across all provinces. That is where our concern comes from—not that you may have misworded it.

Mr Beer: I want to follow up on this question of health care only in section 14, where there are the three clauses. This would be a question to the parliamentary assistant. The way it is worded in providing health care to individuals, it does not refer to a specific area or to a facility. But is subsection 14(2) intended to catch those who are working as occupational therapists in other places? Or did the review very deliberately want to confine it to what the review determined to be health care so that in fact those working in the workplace or perhaps in schools would not be covered? I would just like to be clearer on that.

Mr Wessinger: Before referring this to counsel for more elaboration, I think it is clear that the concept is health care, not specific health care institutions. But more elaboration can be given on that by counsel. I will ask her to do so.

1100

Ms Bohnen: In the review recommendations which set out the proposed title protection and holding-out provisions, the issue of health care, non-health care, was not addressed at all. If you take a look at what is in Striking a New Balance, you will not see any reference to health care in either the holding-out or the title protection provisions. It was just not there. When legislative counsel came to redraft the review recommendations into the legislation that you see, there appeared to be kind of a vacuum, nothing to anchor the provisions.

Since this was intended to be legislation regulating health professionals, and since all of these professions had, with very few exceptions, agreed to scopes of practice which reflected their activities, whether they be in traditional health care settings or schools, factories and so on, it seemed quite reasonable to anchor the use of the specific title to the provision of health care. But as you correctly point out, the holding-out provision does not refer specifically to "in the course of providing or offering to provide health care."

I suppose when one looked at instances of how the occasions in which a non-occupational therapist might hold himself or herself out as a person qualified to practice, etc, practically speaking, it seems unlikely there would be much percentage in making a misrepresentation of this kind in some sphere of activity entirely unrelated to health care or the kinds of services OTs provide.

The Chair: Thank you very much for your presentation. We appreciate your appearing before the committee today. I think you have heard me tell the others that if there is additional information, you can feel free at any time to communicate with us in writing. We appreciate your appearance this morning.

RESPIRATORY THERAPY SOCIETY OF ONTARIO

The Chair: I would like to call next the Respiratory Therapy Society of Ontario.

Miss MacDonald: Thank you, Madam Chairman, and good morning to the group. I am Margaret MacDonald. I am chairman of the legislation committee for the Respiratory Therapy Society of Ontario. With me are Gisella Quintieri,

who is the president of the Respiratory Therapy Society of Ontario, and Ian Reid, who is the vice-president.

Historically, the profession of respiratory therapy has been known as inhalation therapy in the 1960s and respiratory technology in the 1970s. In the early years of our profession, many services were primarily technical in nature. With development, the profession has increasingly provided therapeutic and diagnostic services, hence the progression to its current title of respiratory therapy.

The registered respiratory therapist is a graduate of an accredited educational program who has successfully passed the registration examination in respiratory therapy of the Canadian Society of Respiratory Therapists.

The fundamental objective of the Respiratory Therapy Society of Ontario is to promote the best possible care for patients suffering diverse cardiorespiratory disorders. The society is very concerned with how the public is served by the profession. We are also the only body representing registered respiratory therapists as well as other uncredentialed providers of respiratory therapy in Ontario. Hence, we have reviewed Bill 43 and the profession-specific acts, especially Bill 64, An Act respecting the regulation of the Profession of Respiratory Therapy, in great detail. We are therefore requesting amendments and/or additions to the following sections of Bill 64: section 3, scope of practice; section 4, authorized acts; and section 15, restricted titles.

If you would like to refer to page 4 in our brief, it deals with scope of practice. A clearer scope of practice definition will enhance the public's understanding of our role in health care. Our scope statement in Bill 64 suggests a limited scope or role, concluding as it does with the phrase "to maintain or restore ventilation." We deal with patients who have compromised respiratory function and do much in our everyday role, be it diagnostic or clinical, to improve their status, thus avoiding the end stage where they actually require assisted ventilation.

In any description of our role or scope it is impossible to separate the functions of the cardiac and respiratory systems. Therefore, the change we are recommending—"to maintain, restore and/or promote optimal cardiorespiratory function"—is much more accurate of our role.

It also expresses our activities in health promotion, which are considerable. An example is the Lungmobile, a public awareness and education program which will be launched in September. The partners in this venture are the Respiratory Therapy Society of Ontario, the Ontario Lung Association, the Ontario Thoracic Society and the Ontario chapter of the College of Family Physicians of Canada.

Respiratory care provided by registered respiratory therapists is ultimately performed under the direction, order or auspices of a physician. Our authorized acts stipulate that they are performed upon an order of a member of the College of Physicians and Surgeons of Ontario. Therefore, the inclusion of the phrase "on the order of a member of the College of Physicians and Surgeons of Ontario" within our scope of practice definition is redundant. It also does not appear in any of the other group's scope statement. Hence, we are recommending its removal.

The next section is authorized acts. Additional specified authorized acts clarify our participation in the execution of procedures carrying significant risk of harm to the public. These additions also avoid the potential for limitation or restriction of our scope of practice.

We did understand at one time that certain acts might be specified in regulations and would not appear as authorized acts. However, when reviewing other professions' acts and also the proposed amendments put forth by the minister on July 31, to avoid limitation, as well as to protect the public, we request these three additional acts. I refer you to page 5 of our brief.

The first authorized act we would like to have included deals with suctioning, "oral, nasal, pharyngeal, and/or tracheal suctioning, with or without an artificial airway in place." This is a routine procedure performed by a registered respiratory therapist that does pose significant potential for risk of harm. In particular, we are concerned when tracheal suctioning is being done if there is an artificial airway, such as a tracheostomy, in place or any suctioning at all in a neonatal practice where certain additional care must be given due to the risk in dealing with these small patients.

The next one is an additional act described as follows, "performing a prescribed procedure below the dermis on the order of a member of the College of Physicians and Surgeons of Ontario." Registered respiratory therapists frequently perform the following procedures: arterial blood gas sampling, venipuncture, intravenous line insertion and the manipulation of pulmonary artery lines to relieve wedging or prevent life-threatening arrhythmias, which is currently a delegated medical act. These procedures pose a significant potential for risk of harm, thus necessitating inclusion of this amendment.

The third additional act we are requesting is that of allergy challenge testing, "allergy challenge testing of a kind in which a positive result of the test is a significant allergic response on the order of a member of the College of Physicians and Surgeons of Ontario." Registered respiratory therapists working in health care facilities where their role includes diagnostic services are being called upon with increasing frequency to perform allergy challenge testing. This allergy challenge testing is included in the controlled acts in Bill 43. Again, potential risk of harm associated with this procedure is great.

The next section we are requesting amendment to is the restricted titles. I refer you to page 8 of our brief. Clarification of who we are, by identifying the primary respiratory care givers as registered respiratory therapists, we feel is paramount to public protection. This issue of title has been a primary concern for registered respiratory therapists in Ontario since the HPLR began. To ensure proper identification of an acceptably trained respiratory therapist, and therefore also ensure public safety, an accurate title is key.

Just prior to when the blueprint for regulation of Ontario's health professions was distributed in January 1989, we were informed that the blueprint would not include the term "registered" in any profession's restricted title. Although we were not comfortable with this, it

appeared that the door was closed on that issue. However, at a briefing immediately preceding the first reading of the Health Professions Regulation Act, 1990, and the profession-specific acts, we were informed that nursing had been given "registered" as part of its title. Clearly consideration should be given to other professions to include "registered" as well.

In providing health care, Ontario health care facilities primarily employ registered respiratory therapists. However, some duties are performed by on-the-job trained personnel who function under a variety of titles, such as respiratory therapists, respiratory aides, respiratory therapy assistants, non-registered respiratory therapists and respiratory technicians. Therefore, a second level of respiratory care practitioner does exist. Although our Canadian schools have no recognized training program for this, the United States does.

1110

Again, a registered respiratory therapist is a graduate of an accredited educational program who has successfully passed the Canadian Society for Respiratory Therapists registration examination. The term "registered" denotes that a specific level of prescribed education has been achieved. Just as the titles "registered nurse" and "registered nursing assistant" provide identity and delineate a level of education, so does the title "registered respiratory therapist."

We have no desire to see any unregistered care provider put out of a job. Rather we want the specifically educated and skilled practitioner easily distinguished by the public at the bedside by the title "registered respiratory therapist." We see our previously proposed limited licence to practise covering non-registered care givers as they provide a clearly defined list of specific duties in a given health care facility.

Both medical laboratory technologists and medical radiation technologists are referred to as RTs. The use of "registered" and the initials RRT provide clarification for the public in identification of various health care professionals. We feel it imperative for the protection and the awareness of the public that the restricted title be changed to read "registered respiratory therapist."

I thank you for the opportunity to present these data before you this morning and I welcome any questions.

The Chair: Thank you very much for your presentation. I have a request from the parliamentary assistant to clarify.

Mr Wessenger: Yes, we have a request to clarify with respect to the title matter by ministry staff.

Ms Bohnen: Under the bill only members of your college will be permitted to use either the title "respiratory therapist" or the title "registered respiratory therapist," because that is a variation of "respiratory therapist." There is nothing to stop your college from determining that. All members of the college should always use the modifier "registered respiratory therapist" and the abbreviation so that public awareness of what "registered respiratory therapist" means increases. It will not be possible for unregistered people, non-members, to use the title "respiratory

therapist" in Ontario, so if your college is concerned about a group of practitioners currently using that title, then a means will have to be provided, and is provided within the structure of the legislation, to create a class of membership for the less than fully qualified therapists.

Mr Owens: On the subject of the authorized acts that you propose in your presentation, are you currently performing these acts?

Miss MacDonald: Yes.

Mr Owens: So this in fact, if passed the way it is written, would be a restriction of your current practice?

Miss MacDonald: Yes.

Mr Owens: Do you know of any reason why these issues or these acts were left out? Was it simply oversight or is there any rationale?

Miss MacDonald: We had significant discussion on a number of these items with the HPLR group. Myself personally, I have been involved in it on behalf of the RTSO over the nine years of the history of this project. We were very surprised when it came out, in particular that procedure beyond the dermis was not covered, because some of those things are specifically currently validated medical acts. Again, we felt that the road was blocked, that the discussion had to end there and that our next avenue where I should bring this forth for consideration would be at this particular venue here, with the standing committee and the public hearings.

The Chair: I have a request coming from the parliamentary assistant to clarify.

Mr Wessenger: Yes, I would like to have ministry staff clarify this matter.

Ms Bohnen: The review's intention and the government's belief is that the controlled acts currently specifically authorized to this profession reflect current practice and that those additional invasive procedures which has been mentioned, like arterial puncture and so forth, are currently and will continue to be done under medical direction as delegated controlled acts in this legislative structure. There is no intention to limit the sphere of activity or the hazardous procedures that respiratory therapists are now engaged in.

The issue, I think, is the more narrow one of which legal device is most appropriate given the setting, the nature of the activity and so on. They have proposed that it be permitted to members of their profession in essence through regulations under the act, which would specify the prescribed procedures they may do. The government's intention was that this be viewed as delegated authorized acts from a physician.

Mr Beer: You mentioned that you have been working on this for some nine years. I think members of the committee are reaching the point where they feel a medal should be struck for anyone who has managed to stay with this throughout that whole period.

I just want to go back to your scope of practice and your point about the "education of the public in order to"—yesterday in Ottawa we also had a group that was talking about health promotion—but where that sort of

sense of education is involved. I take it that you want this here in order to underline that particular function. There is nothing that would preclude you from doing it, but this would give it a greater place, so to speak, in your scope.

Miss MacDonald: And it is something we do. The example I gave verbally of the lungmobile is something that is outside the institutional setting, but it is also something we do every day in counselling our patients and preparing them to go home. There is an education component to a great deal of our everyday practice. We thought to leave it out was not fully illustrative of what we did, that we have that as not only our day-to-day practice, but the things we do outside that help to increase the awareness of the public.

Ms Haeck: On page 7 of your brief you raise an interesting point under rationale: "Registered respiratory therapists working in health care facilities where their role includes diagnostic services" in relation to allergy challenge testing. Could you explain the diagnostic services you would perform in an allergy testing situation?

Miss MacDonald: Yes. Challenge testing that we participate in is actually determining whether the patient has a reactive airways disease, so we are actually challenging them by having them inhale a substance that is known to cause a response in certain individuals. Based on their response to this test, it helps the physician determine whether they have, for instance, a reactive airways disease.

Ms Haeck: Okay. This is one test I have not had. I thought I had had them all. Let me just get some expansion from you on this. Basically it has already been determined by the doctor, or there has been some suspicion on the part of the medical practitioner, that there is a problem in this area and he or she then prescribes the test, an inhalation, be it essence of peanut butter or whatever. You provide a mist of this substance into the air passage and you provide a record of what transpires.

Miss Quintieri: Yes.

Miss MacDonald: Yes, a certain degree of response is considered indicative of a particular problem. To be more specific, one of the primary challenge drugs per se is histamine. It is known to help produce—

Ms Haeck: I have popped a few of the antihistamines.

Miss MacDonald: Yes. It can produce dramatic response in someone who is asthmatic, for instance. It is a known substance and if a response occurs to a specific degree it is indicative of asthma, for example, asthma being one type of restricted airways disease.

Ms Haeck: We have been bouncing around the ball of diagnosis and assessment for the last three and half weeks. As I have described it, it is trying to nail the jelly to the wall. How would you see that this is diagnosis as opposed to assessment?

Miss MacDonald: It helps the physician to diagnose. We do not diagnose. We are purely reporting the results of the tests we do. We are not performing any diagnosis.

Ms Haeck: Okay. That is what I needed.

Mr Reid: We are providing diagnostic information to the physician to make a judgement call.

1120

Ms Haeck: You are providing a portion of what they described yesterday in their presentation as one of the tests in that whole differential diagnostic process.

Miss MacDonald: That is right. Our practice is primarily clinical and/or diagnostic. Things like exercise stress testing, this allergy challenge testing and pulmonary function testing are diagnostic. We do a fair bit of diagnostic work, but we prepare the results for the physician to then look at and make the diagnosis.

The Chair: Thank you very much. We appreciate your appearing before the committee this morning. As I have told other presenters, if over the course of our hearings and deliberations there is additional information you think would be helpful to the committee, please submit that to us in writing by the clerk. Thank you for appearing today.

MARY McLELLAND

The Chair: I call next Mary McLelland. Please come forward. Welcome to the committee.

Mrs McLelland: Good morning. My name is Mary McLelland. I am the very proud mother of a five-year-old boy who was born with the physical challenge of cerebral palsy. His name is Sean Michael. Anyone who would suggest that I cannot continue to hear directly from my speech therapist about my son's speech diagnosis and follow-up therapy plans obviously has never walked in my shoes.

I am outraged. I am the one who has to live with a child who cannot crawl, sit, stand or walk by himself. I am the one who has to carry him and his manual wheelchair up two flights of stairs to reach his speech therapist. I am the one who does this most willingly and with the greatest pleasure, because this particular therapist is there for Sean and the achievement of his fullest potential. Why would I question the credibility of my speech therapist when she was recommended to me by my son's paediatrician? He obviously respects her work, and so do I.

Why would I go to his paediatrician when I do not even know if he has had time to read the initial assessment findings or the quarterly follow-up reports? How can I expect him to answer my questions as to the clarification of the therapy program, or tell him that the intense content will be too stressful for Sean and will accomplish nothing but frustration? His specialty is to diagnose and treat critically ill children. Sean is not sick. He is physically challenged and that his paediatrician has told me and has given me the correct terminology for his lack of gross and fine motor skills.

Our speech therapist's specialty is the development and implementation of the appropriate speech and language program for my son. We must work together as a team or there will be no progress. Sean must first trust me to make the right choice for him and then trust the therapist to allow her to work nose to nose with him, literally. I in turn must trust her personality, her educational background and her methods. She must trust me to know that I will reinforce what she has taught Sean at each session.

This essential aspect of our team trust can be clearly illustrated through the following example. Sean's type of

cerebral palsy will never allow him to lose his startle reflex; however, he will learn to control it. Most children lose it at four months of age. Needless to say, anything or anyone that comes up to him from behind without warning or anything very noisy will cause his whole body to extend, and he will then proceed to cry uncontrollably until the situation is explained to his satisfaction.

Sean started speech therapy at two and a half years of age. Due to the fact that our therapist is so excitable, outgoing and very keen about her work, the first three hourly sessions were lost to a crying, frightened little boy. I therefore suggested to her that she not come into the room for the start of the next session, but rather put a toy on the floor in the middle of the room that we could play with that would allow Sean to use what little vocabulary he had. She stayed out in the hall for 10 minutes and was finally able to hear Sean say his few words. She then crawled into the room and sat in one corner while we continued to play with the toy. All the while, Sean was keeping an eye on her.

The next session, Sean allowed her to sit next to him while she whispered her instructions to me. During the following session Sean was lifted by the therapist on to her knee. She had won his trust. I could now relax and together as a team we were ready to move ahead. Our speech therapist was secure within herself to believe in the fact that a mother knows her child best. As a mother, I need therapists who are willing to acknowledge me as something other than just his mother or, "She's only the parent," but rather, "She's an important part of the team."

As a result of three years of weekly sessions, Sean is now able to say hundreds of single words and a few three-word sentences. I will never be able to thank our speech therapist enough for all the man-hours, all the encouragement and all the energy, and most especially for all the late-night phone calls she received from a stressed-out mother who felt she was failing her son because she was burnt out. No physician could ever give this kind of consistent support to someone who seemed to be at the time a drowning mother.

Sean will start kindergarten this fall and so we must leave the direct services for the school system. We are actively looking for extra help, as the school system cannot possibly offer the number of hands-on hours we have become accustomed to. Therefore, please do not add to my stressful life by allowing untrained individuals to tempt me with their shingle. Only qualified speech and language pathologists can be permitted to use the title "speech therapist" wherever they choose to work.

Specially trained speech therapists deserve our respect for the many years of required education and the number of clinical hours they have accumulated. They should not be shrugged off or disregarded by anyone who one day wakes up with a bright-eyed notion to play speech therapist. This is real life we are talking about, not some temporary whim. If you pursue this line of wasted parent-physician time and the OHIP cost of doctor visits by also involving the physiotherapists and occupational therapists, then you will see me here for a second and third time.

Do me and other voters who have physically challenged children a favour: Leave the system the way it is.

Do not change the direct services we already have with our speech therapists, and please protect us by enacting legislation that will restrict just anybody from calling himself or herself a speech therapist. They must be educationally qualified. In conclusion, please note that we do not need go-betweens, we do not need need more appointment bookings and we do not need to be part of a power struggle; however, we do need upfront, honest and detailed assessments by someone we can trust and who we know is there for the betterment of our children's future. Sean's speech therapist has become his trusted worker and friend. She is my lifeline. Do not pull the plug. Thank you.

The Chair: Thank you very much for a very thoughtful presentation before the committee. We have a request from the parliamentary assistant, Mr Wessinger.

Mr Wessinger: I would like to assure you that there is nothing in the legislation which would restrict the right of your speech pathologist to discuss the treatments she is giving to your son or the assessment of his condition. In fact, in the legislation the assessment of speech and language functions is given specifically to speech pathologists and that assessment includes the right to communicate that assessment and discuss the treatment with you. I can assure you there is nothing in the legislation that would change that relationship.

Mr J. Wilson: Mrs McLelland, although I would suggest you keep a copy of this Hansard and if you run into any problem mail it back to the parliamentary assistant none the less I am curious to know how you first thought to go to a speech-language pathologist or a speech therapist and how at the present time, under current conditions, you would know whether that was a qualified person or not.

Mrs McLelland: She was recommended by the paediatrician.

Mr J. Wilson: Oh, she was recommended. Okay.

Mr Beer: This is along the same line, because it relates to the title. In your own experience, since you have been working with the speech therapist, have you come across other people who were pretending to be speech-language pathologists or other parents who were in touch with who have challenged children?

1130

Mrs McLelland: Who pretended?

Mr Beer: Yes. Is that something that you as parents sense is out there and is confusing to you in making—

Mrs McLelland: I have to say, in all honesty, I am a very protective person. I have an excellent paediatrician, and any specialist who has been given to my son and myself—as I say, if I joke, we have horseshoes around our necks—has just been absolutely ideal. I have spoken to other parents who have unfortunately had trained speech therapists who are not there for their children. As in every profession, you have the good and the bad. But myself, as I said, I am very protective, so I have not met anyone who has pretended to be.

The Chair: Thank you for your presentation today. We appreciate your coming before the standing committee

this morning. I know that because of your interest you will probably monitor the results of the committee. You should feel free at any time to communicate with us in writing or be very comfortable to contact personally any of the committee members or your own member of the provincial Parliament if you want to discuss the matter further.

Mrs McLelland: Thanks for your time.

ONTARIO TEACHERS' FEDERATION

The Chair: I call now the Ontario Teachers' Federation. I ask that you come forward. You have 20 minutes for your presentation. Please begin by introducing yourselves to the committee and we ask you to leave a few minutes for questions from committee members. I know you are very experienced at appearing before legislative committees, but I try to give everyone the same information so that we are clear on it. Please begin your presentation now.

Mr Poste: I am Ron Poste, the president of the Ontario Teachers' Federation. I am pleased to have assisting me this morning Margaret Wilson, our secretary-treasurer, and Ruth Baumann, one of our executive staff members. Contrary to your remarks, I am not used to presenting to committees like this. I became the new boy on the block last week.

The Chair: Congratulations. Nobody here bites. We are actually in a very good mood this morning. I notice everybody is smiling.

Mr Poste: We certainly do appreciate the committee's altering its schedule to hear from us at this time. We had a conflict and were unable to present when we should have done so. We are pleased to be able to appear before you and present concerns of the Ontario Teachers' Federation about Bill 43.

The federation represents over 126,000 teachers in the publicly funded elementary and secondary schools of the province. We have also discussed our brief with a subgroup of our members, the Ontario School Counsellors' Association. They hoped to be represented this morning, but a funeral took their representative off on a more important task. We have discussed our brief with them and they concur with the points we are going to present.

We recognize that it is intent of this legislation to protect our citizens from harm and misrepresentation, but it creates restrictions within the educational environment which cause us concerns. We would like to outline these to the committee at this time.

Our concerns are not solely within the Ontario Teachers' Federation. When the first draft of this bill was introduced, we discussed our concerns with the Ministry of Education. The concerns were also felt by that group, and appended to our submission is a letter from Robert Mitton, the Deputy Minister of Education, to the Deputy Minister of Health, expressing some of the concerns of the Ministry of Education that were initially brought up with the legislation.

I think our concern can be summarized in the paragraph that begins at the bottom of page 1. There is considerable overlap between health care, social services and education in our society. The legislation presently before

the committee, with its emphasis defining and distinguishing the functions of various health care providers, must be reconciled with the increasing thrust for better integration of services and for better interdisciplinary co-operation.

We have serious concerns regarding the very general definition of diagnosis as it is contained in paragraph 26(2)1 of the bill. It is my understanding that the members of the committee do have the legislation, and our concern, if you wanted to focus on that, is on page 8, in that particular part. The communication of a conclusion identifying why a student is behaving in a certain way seems to be incorporated in that definition, and that, we believe, is going to detract from the quality of service that we have been providing within education.

Guidance counsellors, special ed teachers, phys ed teachers, vice-principals, principals, teachers trained in children's educational and psychological needs, often called psychometrists, do make judgements about the performance of students. The education legislation itself does require that assessment be done before a pupil can be identified as exceptional. We are required as teachers to "assess students' particular social and emotional needs and make recommendations for referrals to or consultation with other staff or community agencies." It is very difficult, as we see it, to distinguish between what is a mental health issue and what might be considered to be an educational issue.

We are also called upon to counsel students and families. The teacher or guidance counsellor quite often will refer students to a specific agency or service provider for more in-depth consultation. We have a concern that diagnosis as it is defined in the legislation now will prevent or stop some of the activities that have been going on.

Within the province, small communities do not have full reference to the wide range of services. People involved in education in these small communities quite often are called upon, as trained professionals, to do some of this consultation and referral. We have a concern that the legislation will jeopardize that service for small communities.

Related to that in small communities but not directly within education, and perhaps you have already heard of it, is our concern that much of the advice given by pastoral counsellors might also be terminated by this legislation.

Schools now, with the integration of exceptional students into them, quite often could be termed health care settings under this legislation. Our question is basically, what restrictions will apply to these services, particularly in the area of speech and language assessment, if they are provided within the school? Will this become a health care setting under this legislation? The program is there. The traditional involvement of schools is changing to provide much more in the area of health care, and we do not see the interface between what is now happening and what is anticipated under this bill.

If you track it through from the educational point of view, and again I would refer you to the appendices of our presentation, policy memorandum 81 focuses specifically on the provision of health support services in school settings. This was the start of bringing some facets of health care into the educational environment. Further clarification was given in 1989 in a memorandum indicating that it was

acceptable within the school setting to perform clean catheterization and also shallow surface suctioning by trained personnel, but not necessarily personnel who had been trained to the extent that was traditionally expected. We now have teacher assistants who are trained and able to undertake these particular procedures with students.

As we read the proposed bill, this would prohibit the continuation of that and require that the more fully trained health service professionals, nursing assistants, VON, health unit staff, would take over that function. We really wonder if that is the intent of this particular bill.

One of the major concerns we have is an interdisciplinary approach to the provision of service for students. The Ontario Teachers' Federation applauds many of the moves of this past year to try to integrate the provision of services between or among intergovernment agencies. In the report of the Advisory Committee on Children's Services, Children First, this seemed to be one of the major concerns addressed. It states: "Services are too fragmented, over-specialized and overburdened...The provincial government should promote models of service integration and collaboration that simplify access to service and rationalize the roles of our limited resource of trained specialized service providers."

We believe we have some of these in the schools. Our concern is that this focus, which would tend to perhaps even more fragmentation, would remove a service that our children now have.

I think our major concerns, in summary, can be focused on that definition of controlled act, and as we read it, how does it apply in the schools? If it does have the effect of fragmenting services rather than fostering more integrated approaches, then in our opinion our children will not be as well served in the future as they are now.

The federation does ask the committee to consider several important things, and I guess I would emphasize the point made by the previous presenter. It is important in this province that legislation prohibit misrepresentation. It is important in our mind to confine the diagnosis to an area where there is expertise, and perhaps the law might want to focus on confining medical diagnoses but at the same time acknowledge the legitimate diagnostic role of professionals who have training in other areas. It is important, I think, that all professionals recognize the limit of that training and stay within it. If that happens, then I think our people are well protected.

We would also advocate that the present prohibitions on the practice of medicine without a licence be maintained.

That I think summarizes our presentation, and if there are specifics that committee members would like to address, we would be only too happy to expand on them.

1140

Mr Jackson: I appreciate receiving this detailed brief and as well the response from the then Deputy Minister of Health Barkin to Deputy Minister of Education Mitton's letter. When I read the Barkin letter, I see clearly the suggestion that some of your concerns, in their opinion, have been met, but "it may be possible to resolve at least some

of the anxieties of unregulated practitioners through amendments to the wording of the controlled act."

You have laid out three items for our consideration on page 7. My question is, have you had any opportunity to dialogue with the Ministry of Health or Ministry of Education with respect to preferred options or potential amendments?

Ms Baumann: No, we have not. At the time that we worked with the ministry on the letter that went from Deputy Minister Mitton to Deputy Minister Barkin, the approach that was being looked at was some kind of an exemption. As the months went on and the legislation changed and we took another look at it, we were not sure that in fact that remained as a sensible option, that you could just exempt a whole field as big and in its own way as ill defined as health probably, that is, education, so we began to try to look for something that might address the need of the protection of citizens while at the same time not overregulating.

Mr Jackson: As I noticed in the dates of the letters, it is clear that the government tabled some amendments post-April 26, the date of the letter from the Deputy Minister of Health. Have you read the amendments and do you see any comfort in them, and if not, have you had an opportunity to directly contact either of the ministries since the tabling of those amendments?

Ms Baumann: We have spoken with the Ministry of Education. We do not have the letter from Dr Barkin to Mr Mitton. We know that such a letter did go. We know that the basket clause, as it is referred to in the letter from Mitton to Barkin, is no longer in the legislation, and we were quite pleased to see that go. But the general concern in terms of the provision, particularly of counselling and educational assessment services within the school, was one that, in my conversations with Deputy Minister Mitton's executive assistant, I think we continue to share with them.

Mr Jackson: Madam Chair, if I may, just for purposes of the Hansard record, the letter I was quoting from was just tabled with the brief but was not part of the brief that we just received from the OTF. That is a memorandum from Linda Bohnen, counsel for this legislation, from the Ministry of Health. We have just received it now and perhaps we can share that as well with the deputants, and I should thank Ms Bohnen for having that here today for our consideration.

Mr Beer: I also shall be referring to the letter from Dr Barkin and it would be a question to the parliamentary assistant. It is set out that "no person shall perform," etc, "in the course of providing health care services," and then in the different controlled acts there is another one, the holding-out clause. In the letter stress is put on the fact that, look, we are only talking about people providing health care services, yet if one thinks of what happens within a school setting and certainly the discussion around children first and where that might go, mental health and so on, one can see where that starts to get perhaps a bit of a murky line.

In talking about the amendments at the end that Mr Jackson referred to, and the point made earlier that the

legislative drafters wanted to anchor that clause to something specific, what would be the difference in subsection 26(1) if it did not contain the phrase "in the course of providing health care services" but was more generic? What is changed in that?

Mr Wessenger: I will ask ministry staff to respond to that.

Ms Bohnen: I think the issue of the language in the course of providing health care services has a very different significance in relation to the controlled acts than it does in relation to the holding-out clause or the title protection clause. It is important, we believe, to confine the controlled acts to the delivery of health care services because we can all imagine, I think, many examples in which people's bodies are invaded or things are done which would otherwise inadvertently be prohibited or restricted to regulated health professionals. The government has no desire at all to regulate those activities under this legislation.

I think that the concerns being raised by the OTF and the Ministry of Education have to do, first of all, with not inadvertently precluding teachers and other education professionals from performing assessment activities, and that is the diagnosis-assessment issue you have heard many groups talk about. Then, when we get into another issue they raise, which is that many health services, or things that look like health services, are provided by teachers' aides, speech-language pathologists, occupation therapists, whoever, within the school system, that is another whole set of issues.

The most pressing one being raised would be dealt with by the way in which attendant care services will be provided. I do not know if this group would be aware of the fact that all Health ministers who have participated in bringing this legislation forward have expressed and confirmed their intention to make exceptions for the provision of attendant care services such as the suctioning, intermittent catheterization, and so forth that you refer to.

Mr Beer: Can I just follow up then? One could look at what it is that teachers may do in the course of a regular day by looking at something under section 28. Right? I do not want to misinterpret what you are saying.

Ms Bohnen: I think what I am saying is, the kind of possible amendment that Dr Barkin was referring to was the same possible amendment the minister was referring to when she came before this committee and said: "I know there are outstanding concerns about diagnosis-assessment. I hope the committee will guide me in making an amendment in that area." It was the deputy minister's view, and I think it is now the OTF's view, that just creating a statutory exception for education professionals would probably raise more difficult issues than it would really solve, and it was not the best way of approaching the issue.

The Chair: Thank you for appearing before the committee today. We appreciate you making such an

excellent presentation. If in the course of the deliberations of the committee there is additional information you think would be helpful, I know you are aware that you can communicate with us through our clerk. Thank you for appearing today.

Is Bill Burns here? Mr Burns's appointment time is now, 11:50. If there are any questions of the parliamentary assistant, we could use a few minutes to do that and give Mr Burns a few minutes to arrive, if he is going to show up. Are there any questions of the parliamentary assistant or ministry staff?

Mr Beer: One of the issues that has often come up has been that certain things will be done under regulation. When we are meeting with officials that week of September 16 and 17, I would like to have a better understanding of why certain things would be best placed under regulation and others within the legislation itself. Some of the concerns that have been expressed are around a misunderstanding of, I suppose, the standing of regulations as part of the legislation. It would be helpful to us if we could see that issue a little more clearly, if I could just note that.

Mr Wessenger: I was just going to add to that, perhaps we should include the aspect of delegated acts as well in that, so we could see it as a whole picture.

Mr Beer: Yes. In effect, I guess it would be anything other than the specific legislation which needs to be drafted, drawn up, whatever, and it would have a direct impact on the groups we are going to be regulating.

The Chair: The request is noted and we will ask that that be included during the committee hearings on September 16 and 17. I should note—it was mentioned in a question to the clerk—it is my understanding that on the day Mr Schwartz makes his presentation, which is the morning of September 16, there will be a lot of people interested in attending the session that day. I am wondering whether there is a larger room available.

Since it was brought to my attention I thought I would mention it to committee members. The clerk says that she will check and see if there is a larger room with more seating. It would be unfortunate if people had to stand or felt they were not welcome. Certainly we want to make everyone as welcome as possible to these hearings. The level of interest, I think, is very high.

Mr Burns is still not here. The committee will stand in recess for five minutes and give Mr Burns a chance to arrive.

The committee recessed at 1153.

1159

The Chair: The standing committee on social development is now in session. It is 12 o'clock. Mr Burns has not shown up and therefore has forfeited his time before the committee.

The committee recessed at 1200

AFTERNOON SITTING

The committee resumed at 1400.

ONTARIO ASSOCIATION
OF REGISTERED NURSING ASSISTANTS

The Chair: I would like to call the Ontario Association of Registered Nursing Assistants.

Mrs Steffler: My name is Verna Steffler and I am the executive director of the Ontario Association of Registered Nursing Assistants. With me I have Audrey Shaw, who is the president of OARNA, Gail Bennett, who is the executive assistant of OARNA, and Margaret McDavid, who is the secretary-treasurer of OARNA.

OARNA is a voluntary professional association with about 5,000 members and we are deeply concerned about this legislation. Let me begin by saying that in general OARNA is very supportive of the Regulated Health Professions Act. We liked the open process that was used to develop it and there is no question a great deal of very hard work went into preparing this historic legislative package. Everyone who participated deserves congratulations, and for the most part we are very happy with the results.

However, I have to tell you that OARNA is very much opposed to Bill 57, the act which keeps registered nursing assistants together with registered nurses under one college. In our view, this bill is just like forcing a bad marriage, one that has not worked well in the past and will not work well in the future.

We have tried to put our case to the government, but to be fair I do not really think the minister has had the time to review the implications of this bill, so we are counting on each and every one of you, in all three political parties, to help avoid an unjust and unworkable situation.

As far as we are concerned, there is only one solution that makes sense: RNs and RNAs should each have their own college. That is what we hope you will recommend in the interests of fairness. We do not want to hold up the legislation, but we do need your help in correcting a bad situation.

I thought perhaps it would help you to understand our position if I talked a bit about registered nursing assistants, because I know there could be some confusion about what we do, especially when you compare our role with the role of a registered nurse in our system.

Actually the distinction is quite straightforward. RNAs provide basic nursing services. I am talking about practical, hands-on nursing care in institutions and in the community. By contrast, registered nurses deliver a much broader set of services, care that often involves more complexity and more technical expertise. This is appropriate. RNs train longer and have a wider scope of practice than RNAs.

RNs and RNAs often work in the same places, but contrary to popular opinion RNAs do not always report to an RN. Sometimes our supervisor is a doctor or another type of health professional, or an administrator. Sometimes the supervisor is another RNA.

In most parts of North America, registered nursing assistants are called licensed practical nurses. They are considered

to be a separate profession and are not regulated with or by registered nurses. In Canada, licensed practical nurses in Alberta, Saskatchewan, Manitoba, Quebec, New Brunswick and Prince Edward Island are self-regulating. In fact, Ontario is the only province that regulates our profession together with RNs in one regulatory body.

Based on our experience, we believe that this is a terrible mistake. We have had lots of experience with clustered regulation and we know that it cannot work when the professions involved disagree about their respective roles in the health care system. That in a nutshell is our problem with being regulated in the College of Nurses of Ontario. This should not be taken as an attack on the college of nurses. We do believe that the college tries to maintain its public interest perspective. However, there is no getting away from the fact that sometimes it makes decisions that favour the RN over the RNA, even when the issue has nothing to do with public protection.

RNAs are able to deliver essential services at a very competitive price. Our profession is one of the most important keys to a more cost-effective health care system. However, in our view, being jointly regulated under one college has stood in our way and will continue to block the development of our profession as a cost-effective alternative to the registered nurse.

The truth is that our respective professions compete with one another and under the current structure of the college it is an unfair competition. Let me explain. There are about 105,000 RNs in Ontario and about 35,000 RNAs. The representation on the college council reflects this distribution. The current CNO council has 32 members; eight are public representatives, 16 are RNs and eight are RNAs. The proposed law would change the composition of council to increase the proportion of public members, but even so, RN council members will continue to outnumber RNA members two to one.

From our perspective, this structure does not look like self-regulation for RNAs at all; it looks like the regulation of RNAs by RNs. We do not think that RNs should have this kind of power over our profession.

Staffing patterns and the focus of work at the college also reflect the inequality between our two professions. RNA membership fees constitute about 25% of the CNO budget, but only about 13% of its total revenues are actually spent on RNA affairs. Of the 19 professional staff working at the college, there are 16 RNs but only three RNAs.

RNAs are a separate profession. We say that even though our profession learns some of the same things and performs some of the same duties as the registered nurse.

The truth is that the knowledge base and scopes of practice for many health professionals overlap to some degree. RNs, RNAs, orderlies, health aides, midwives and ambulance attendants learn some things in common and perform some of the same job functions, but that does not mean they all ought to be regulated under the college of nurses. Nowadays, registered nurses perform many

functions that used to be restricted to doctors only, but no one thinks that RNs ought to be regulated by the College of Physicians and Surgeons of Ontario.

The issue of self-regulation hinges on the risk of harm to the public. This legislation has identified 13 types of health care activities that could result in harming the public if carried out by unqualified personnel. Called "authorized acts" in the RHPA, these potentially harmful interventions have been allocated among various health professions on the basis of their education and competence to handle them. And so, while it is safe for an RN to perform all of the job functions of an RNA, the reverse is not the case. Similarly, a dentist is competent to perform all the functions of the dental hygienist, but not the other way around.

On the same basis that dental hygienists are considered a separate professional group under this legislation, we hold that RNAs belong to a separate profession, one that is related to but distinct from registered nurses.

Bill 57 does not recognize our separate status as a distinct profession, but other nursing organizations do. The Registered Nurses' Association of Ontario, for example, believes we are so distinct we should not be called nurses. Both RNAO and the Ontario Nurses' Association, Ontario's largest nursing union, have argued for greater distinctions between RNs and RNAs in the standards of practice. Both positions are consistent with the idea that RNAs are a separate profession.

Unfortunately, Bill 57 perpetuates an injustice. It allows one profession to dominate another by pretending that we are all members of the same group while maintaining the need to have two different categories.

We do not think this adds up to self-regulation for RNAs, particularly in view of the fact that RNs and RNAs compete with one another in the marketplace for jobs. This reality can and does influence the decisions made by the college of nurses.

1410

The college of nurses makes critical decisions affecting our profession. They decide about our standards of practice, our competence to perform authorized acts, and our access to training. Because RNs outnumber us on council, and because they have more education and more status than RNAs, whenever the interests of RNs and RNAs collide, RNAs are likely to lose. Let me give you an example. Over the years physicians have asked the college of nurses to allow RNAs to administer intramuscular injection. Until the publication of their 1990 Guidelines for Decision-Making, the college always refused. Now they say it depends on the client population. For young, healthy schoolchildren the answer was yes. For the frail elderly the answer continues to be no. We do not think this decision makes sense. RNAs can administer subcutaneous and intracutaneous injections; why not intramuscular ones too? The training required to give all three types of injections is virtually the same.

We think this decision by the college was primarily driven by marketplace considerations, not the public interest. We do not think it has anything to do with protecting the public from harm. By making it impossible for RNAs

to give intramuscular injections, the college was protecting jobs for RNs and adding unnecessary costs to the health care system.

Let us look at another example. Some years ago, OARNA was trying to promote the idea that foot care ought to be part of the RNA basic educational program. For two years we got nowhere at all in our discussions with the college. The CNO only changed its mind when an influential chiropodist from Britain and the Ministry of Health intervened on our behalf.

A fundamental principle of self-regulation is the idea that one professional group must not dominate or dictate to another, but that is what will continue to happen unless RNAs have their own separate college.

During the review conducted by Alan Schwartz, it was quite clear that RNAs, as a professional group, qualified for separate self-regulation. We met each and every one of the government's criteria. In fact, we were actually told at one point that the review committee was going to recommend a separate college for RNAs. We were very disappointed when it did not happen.

My presentation here today has focused on the main reasons why Bill 57, An Act respecting the Regulation of the Nursing Profession, is unfair and unworkable. I want to emphasize that your decision about this is primarily a political decision, not a bureaucratic or technical decision.

I hope you will agree with us and that you will recommend that:

1. The government withdraw Bill 57 and instruct the Minister of Health to draft two new bills providing for two separate colleges, one for RNs and one for RNAs, who should be called registered practical nurses.
2. The government refer to the Regulated Health Professions Advisory Council for technical advice about an appropriate scope of practice for RNAs, and our competence to perform authorized acts.
3. Finally, that RNs and RNAs continue to be regulated under the Health Disciplines Act until such time as the new bills are passed and proclaimed.

Please note that it is not our intention to hold up the passage of this important legislation. We believe that by adopting these recommendations the rest of the legislative package can and should go forward.

Although this presentation has concentrated on the issues of greatest concern to us, OARNA does have a small number of other changes to suggest with respect to this legislation which are contained in our submission entitled *Other Issues of Concern*.

One of the most important to us is our title. We want to see the word "registered" in front of the term "practical nurse" whenever it appears in the legislation. In several places in Bill 57, the word "registered" was omitted, probably just by accident.

Another issue we want to challenge is the government's amendment to Bill 57 which strikes out "on the order of a qualified person" and replaces it with "on the order of a member of the College of Physicians and Surgeons of Ontario."

We think this amendment is contrary to the intent of the legislation. It would mean, for example, that a midwife

or a dentist could not give orders to a registered practical nurse for certain types of medication. We do not think this change makes any sense and urge you to retain the original wording of the section.

I want to thank every one of you for listening to our presentation. If you have not already done so, I want to urge you all to read the brief called "A Question of Fairness" before coming to a final decision. It gives much more detail about our case for separate self-regulation for RNAs.

Mr Owens: Thank you for the excellent presentation this afternoon. I gather your main concern with the legislation, other than the number of points you raised towards the end, is the issue of not receiving your own college. I am wondering, in terms of fulfilling the intent of the legislation, which is to open up the medical profession to the public, how would the public benefit by you folks having your own college rather than being regulated under a singular college as you are now?

Mrs Steffler: There are a few answers to that one:

A Question of Fairness points out the fact that our scope of practice is being held down or changed as the will so desires, which does not allow the profession to meet the needs of the public. With two separate colleges, I think the public would know who to approach about what. Each profession arose on its own, and each profession would have a working relationship with the other at arm's length, instead of our profession being more or less being stymied by another profession.

Mr Owens: In terms of how it works in the other provinces that are regulated or have their own separate colleges, how are the relationships between the different types of nurses, the RNs and the LPNs?

Mrs Steffler: I will let Audrey respond to that. She is president of our national association.

Ms Shaw: Just recently, three years ago, Saskatchewan achieved self-regulation apart from the RN profession, and a year before that Alberta did. There are three other provinces that have self-regulation and their own separate college, and what we have found with Saskatchewan and Alberta—we monitored what happened after they separated and formed their own college—is that we noticed that the relationship between the two professions actually improved, that they got along a lot better because they were on a level playing field. You have liaison meetings with them to discuss issues of mutual concern within the health care system. You speak and have mutual respect for each other and meet as equals, whereas being within the same college creates a conflict.

You mentioned, when Verna answered the first question, that the mandate of a self-regulating college is to protect the public. If you have two professions that cannot agree and there is conflict then it will interfere with that mandate. It cannot help but interfere. We are all human beings. If you have a separate college for RNs and RNAs, then the focus can be on that mandate of protecting the public interest and you will not have the conflict of the two professions.

Mr J. Wilson: Thank you very much for a very good brief. I was just wondering what explanation you have been given, if you have been given one, from the review committee as to why it did not recommend a separate college for RNAs, given that other provinces have moved in that direction.

Ms Shaw: The reason given to us was that we did have representation at the College of Nurses of Ontario and that we had a voice there. We do have a voice there and we do have representation, period, but we do not have self-regulation. We are regulated by the RNs. Right now the college council is 16 RNs, 8 RNAs, 8 lay people, and the proposed new legislation would be 17 RNs, 9 RNAs and 11 lay people. To me that does not look like a self-regulating system, especially for RNAs.

Another reason given was that dental hygienists, who are a much smaller body than we are—we are the second-largest profession—were given a separate self-regulating body, there being a conflict because they were hired by dentists and we were hired by institutions. I have yet to see an institution hire a person. It is the person within that institution who does the hiring. Historically, at most times within the nursing department, it has been the director of nursing who has the input, or the unit manager now because it has been decentralized in a lot of hospitals. It is the patient care manager who has the input on who gets hired and that person just happens to be an RN.

1420

Mr Wessenger: I would like to have the ministry staff give some explanation of the reasons.

Ms Bohnen: I think, Mr Wilson, your question was why did the review not recommend a separate college. The fundamental reason for the review's recommendation, as we understand it, is that nursing is one profession. The review did not believe there was a distinct scope of practice particular to the registered practical nurse as contrasted to the registered nurse; rather, there was one profession with two levels of practitioner.

The Chair: We have 30 seconds remaining and I have one additional question.

Mr Beer: It follows along with respect to the scope of practice. Within 30 seconds, what would be the fundamental difference there? You have referred to your scope of practice. How would you define the RNA's scope of practice vis-à-vis that of the registered nurse?

Mrs Steffler: I think we are trying to point out that there is an overlap with everyone. Whatever the RNA does, the RN can do, but also if you take a look at what medicine does, you can also say the RN can do a great deal of the doctor's scope of practice. I think what we find through this whole health professions review is that everyone has a degree of overlap with everyone else. If we did not, we would not be under a Regulated Health Professions Act, would we?

The Chair: I would like to thank you very much for your presentation today. I know you are aware that if there is additional information you think would be helpful for members of the committee, you will

submit further information in writing through our clerk. We appreciate your coming before us today.

CAROL KUSHNER

The Chair: I would like to call next Carol Kushner.

Ms Kushner: My name is Carol Kushner and I am a consultant to a number of health care organizations interested in this legislation, but I am here today as a private citizen with a particular interest in quality assurance.

As some of you may know, I participated with Cathy Fooks and Michael Rachlis in a research project in 1989 that looked at Canada's regulatory bodies and what they were doing in terms of the quality of professional practice.

Specifically, we looked at five professions: medicine, optometry, nursing, pharmacy and dentistry. We discovered that although each and every one of those organizations did for-cause investigations of quality, that is, investigations that were triggered by complaints, only about half had any kind of proactive quality assurance program.

There were quite a few reasons to explain why this was the case, why so many were uninvolved in doing routine audits, including reasons like lack of interest and lack of resources, but the main reason was that many of them lacked the legislative authority to do this kind of routine assessment. I am glad to say that, when it passes, the Regulated Health Professions Act is going to clearly stipulate this mandate for colleges in Ontario. I think that is a major step forward.

That being said, I do have a couple of concerns about the smooth operation of quality assurance programming in Ontario even with this historic legislation.

The colleges governed under Bill 43 are subject to identical terms and conditions, but they are not all equal. They differ quite a bit in terms of their size and in terms of their resources. I think it is fair to say that some of the very small colleges are going to have a very difficult time carrying out meaningful quality assurance programming on their own. The truth is, I would guess that only about a handful of the colleges established under this legislation will be able to develop good, stand-alone programs.

It seems to me that if the government is serious about quality assurance programming, we need to recognize that at the moment the infrastructure to do that simply is not there for the vast majority of health professions. Take, for example, the problem associated with developing standards.

As you probably know, quality in health care is not just a matter of making sure the care is well executed. I do not mean to underestimate the importance of that. It is terribly important. We do need to know that whatever is being done is done well. But high-quality care also depends on making sure the practitioner is making good decisions. Usually there are choices to be made about alternative types of therapies and interventions so that quality of care also means doing the right thing, making the right choices.

People vary an awful lot in the way they respond to treatment and we cannot always assume that just because we get better following a treatment, we got better because of what the health practitioner did to us or for us. It is just not that simple. Only scientific research can tell us which therapies work best and for which kinds of people. Unfor-

tunately, most of the time this kind of scientific evidence simply does not exist.

This was a surprise to me when I started to study health sciences research and it may be a surprise to some of you, but the fact is that most of the time health professionals really and honestly do not know whether the interventions they use every day work or not. This is true even of medicine which is clearly, I think you would agree, the most scientific of disciplines. Some 80% of therapies they use have never been subjected to systematic rigorous scientific evaluation.

Only technology assessment can answer these kinds of questions, and for the moment most technology assessment focuses exclusively on medical practice, what physicians do. We do not know what the effect of nursing care is or other health professional interventions. So the first structural barrier I see to meaningful quality assurance is the lack of scientific evidence on which to base standards.

The second structural barrier has to do with how much it costs to run good quality assurance programs, and for this I want to refer members to experiences from the province of Quebec. Quebec is the only place in Canada where every profession is required to conduct professional inspections. I think in the research I mentioned earlier each of the five professions we studied had some form of quality assurance program.

In 1984, for example, physicians in Quebec spent about \$1 million—actually over \$1 million—on their professional inspection program. It represented more than one-third of the total expenditures of the Corporation professionnelle des médecins du Québec. In the same year, Quebec nurses spent almost as much as doctors, some \$875,000. However, the government of Quebec explicitly recognizes the financial inequality of professions by giving out grants to support professional inspection programs. Sometimes these grants actually pay for most or even all of the costs associated with QA. A table is attached to my written submission that will give you some more information about what happens in Quebec.

I think it is fair to say that without some kind of similar program here in Ontario, many colleges will fail to implement good QA programming. They will not be able to live up to the requirements of this legislation. So the second structural barrier to quality assurance in Ontario is financial.

Finally, I want to draw your attention to the enormous potential for cross-pollination among and between health professions. Quality assurance is a rapidly developing field and we could avoid a lot of wasteful duplication of effort by making it easier for colleges to find out who is doing what, what is working elsewhere, and helping them to adapt that information to their own circumstances. I do not think that means QA has to look alike in every college, but we do need some mechanism for facilitating information sharing.

So the third structural barrier to quality assurance is the lack of a mechanism for information-sharing and co-ordination. All three structural barriers, scientific, financial and informational, could be overcome by setting up a permanent secretariat with a mandate to help colleges establish QA programs.

Specifically I think this secretariat could give advice about research evidence for standards setting. It could develop a centralized data bank and other resources to make it easier for colleges to organize their own data collection activities. It could provide expert advice about analysis and alternative interventions.

It could also provide financial assistance to colleges too small or too underfinanced to go it alone, and it could become a vehicle for information sharing and co-ordination.

Another point I want to make has to do with the term "quality assurance" itself. A lot of professions I have been talking with are very worried about this term. They think it gives rise to a lot of unrealistic expectations. They are not sure that anyone or any organization can assure quality and they would like the wording changed. They might be right, I am not sure, but what I can suggest, if there is a wording change in the offing, what it might be.

1430

It seems to me that while it may not be possible for the college to assure quality, it is certainly possible for the college to assess and improve quality through its activities, and that might be the kind of wording change they are looking for.

I think there are a couple of things missing from the provisions for quality assurance within the legislation. One has to do with annual reporting. All of the committees are required to give an annual report and there is no detail in the legislation about what ought to be in those reports. With respect to quality assurance, I think this is a failing. Number one, I think the proportion of members inspected or somehow touched by quality assurance programming needs to be reported in the annual report. In addition, I think the expenditures on quality assurance programming would give us an indication of who is doing what and to what extent.

The weakest part of quality assurance is, when you find a problem, what the heck do you do about it? How do you change behaviour? We do not know very much about that. We try certain things, but we are not sure they have an effect. So having some kind of report on what we have done when quality problems were uncovered and how effective it was would be very helpful in monitoring the development of quality assurance programming.

Finally, if colleges are going to get involved in professional inspection into the quality of practice with their members, then the colleges have an obligation to let members and the public know what criteria are going to be used to evaluate their performance. I believe both of these concerns ought to be addressed in the procedural code.

There is lots more I could say about quality assurance but my time is up.

Mr Beer: Thank you very much for focusing on this particular issue. It has come up but you have really looked at it in some depth. Your proposal about a secretariat, is that something you would see being perhaps connected to the proposed advisory council or totally separate?

Ms Kushner: No, in fact, I think it could make a great deal of sense to have it attached and reporting to the advisory council. It seems that way there could be advice

flowing up to the minister and flowing out to the colleges and structurally that would fit.

Mr Beer: Does Quebec have that kind of structure?

Ms Kushner: They have a slightly different organization in that they have a professional code that governs not just health professions but lawyers, accountants and the whole ball of wax. They have an Office des professions du Québec which is established within the terms of that professional code. The functioning of the office, although it does grant subsidies, has not been terribly helpful in facilitating the kinds of things I was discussing here. They have been very arm's length.

The Chair: Thank you very much for an excellent presentation. The committee appreciates your coming today. You are aware that if there is additional information you think might be helpful to the committee, you can submit it in writing to our clerk. Most of the members of the committee know you are the co-author of the book *Second Opinion*, and that is just a little plug.

Ms Kushner: Thank you.

SPEECH AND STROKE CENTRE

The Chair: I would like to call now the Speech and Stroke Centre. Welcome.

Miss Arato: My name is Pat Arato. I am the executive director of the Speech and Stroke Centre, North York. I have with me also Aura Kagan, who is a speech pathologist. I am not a speech-language pathologist but an administrator of a program that employs speech-language pathologists.

The Speech and Stroke Centre is a community agency which provides service to 100 members who suffer from aphasia. Aphasia is a language disorder that impairs the ability to communicate and is usually caused by a stroke. To help our members, we rely on speech-language pathologists who train volunteers to carry out community programs. I have attached further information about our centre as well as the brochure on aphasia, which I have here.

Although we support the principle of Bill 44 to regulate the profession of speech-language pathology, we are concerned about three aspects of the legislation, the restriction of speech-language pathologists from communicating their conclusions, the limiting of the act's title restriction to only people engaged in providing health care services and the lack of protection of the title "speech therapist" and the use of the term "doctor" by speech-language pathologists with a PhD.

Our first concern relates to the controlled act of communicating a conclusion. In the proposed legislation, speech-language pathologists are not permitted to perform this controlled act. We believe this restriction would affect the level of service we can offer our members and would not be in the best interest of individuals with aphasia. Currently all potential clients must be referred by a speech-language pathologist based on a professional assessment. This assessment is then forwarded to our speech-language pathology department. During a subsequent screening interview, further assessment is carried out to ensure that the client will benefit from the program. This information is

shared with the aphasic individual and the family members so that a joint decision can be made together with a professional team regarding future participation.

If Bill 44 is passed as written, our procedures would have to change. We would no longer be able to have our speech-language pathologist discuss her conclusions with the patient. Instead, assessment results would have to be collated and then passed on to the doctor, who would then communicate the results to the patient. This means it would take much longer for the person to know if he was able to enter the centre or not, depending on how quickly he can get an appointment to see his doctor. Also, it would increase our administrative time as we would have to organize our communication through the doctor. Our budget is very limited and if we spend more time in administration, that leaves us less time to train volunteers to run communication programs.

Physicians are usually not knowledgeable with respect to communication problems. It is outside their scope of practice and training. Not only would this bill result in delays of service provision, increased administrative time and costs, but it would also mean the patient would not be given the best information by the person best trained to understand and explain the disorders.

Our members would also be directly inconvenienced by this. Most of them come in wheelchairs as a result of paralysis that accompanies the stroke. Increasing their visits to doctors to get speech-language pathology assessment results would involve more transportation costs, since most of them use Wheel-Trans. It would also mean an increased cost to the already overburdened health care system based on extra unnecessary visits to physicians.

However, our biggest concern about using a doctor to communicate speech-language pathology conclusions is that patients with aphasia will not understand what is being communicated to them. Research has shown that you have to use different strategies to communicate with aphasic individuals. They do not understand speech as they did before the stroke. It takes training and practice to learn how to communicate with them in a way they can understand what is being said to them. A speech-language pathologist has a background in this area while a doctor does not. I am concerned that our members might not be able to make informed decisions if the person discussing conclusions with them is not the one who did the assessment and is not someone who has received special training in how to communicate with aphasic individuals.

1440

The second clause that concerns us is that this legislation only covers acts done in the course of providing health care. The legislation does not apply to settings outside health care. This seems to be allowing a form of false advertising where in one setting you can call yourself a speech-language pathologist but if you are in another setting, for example a school board, you are not regulated. We believe it would be confusing to consumers to control the use of certain titles in health care but then not control them in other settings. The service is the same independent of setting.

We wonder why the legislation does not protect the title "speech therapist." Some of our speech-language pathologists were originally trained in South Africa where their official title and the title appearing on their degree was "speech therapist." We also know that graduates of British schools use the title "speech therapist." Indeed, many places in Ontario still use the old title. We think it is important that consumers know that speech therapists and speech-language pathologists are the same people and therefore both titles should be protected.

Finally, I support the right of speech-language pathologists who have earned a PhD to call themselves "doctor," both without and within a medical setting. The restriction of use of the term to only one setting may be confusing to our aphasic clients and their families. Thank you very much for your time.

The Chair: Thank you very much. It was a very thoughtful presentation. It is good to see you again.

Mr Beer: It is good to get a very practical example in terms of where you are working and how you see this affecting the work you do. As you know, we have heard from many on this particular issue and particularly from speech-language pathologists. Is there a distinction in your mind here, when you are dealing with a patient in your centre, between diagnosis and assessment? I guess that is what we are struggling with. I do not think anybody is looking at stopping you doing what you are doing.

Miss Arato: Maybe I will pass it over to the speech pathologist.

Ms Kagan: Yes, there is certainly a distinction between assessment and diagnosis. What is of concern to us is that there is an unintentional aspect to this legislation in that the logical result of the assessment is to come to some diagnostic conclusion. To give you a practical example, if someone who has been on our waiting list comes in for a visit with an assessment of aphasia, and it appears to us from what we observe that things are not quite as they were on the original report and we redo an assessment, we would possibly then come to a conclusion that may differ in certain aspects from the original report we received. It might turn out that there is an apraxia, for example.

Mr Beer: Sorry, can I just stop you there? That report you received would have come from a doctor.

Ms Kagan: No, at the moment that report comes directly from a speech-language pathologist. So in our minds when we look at this legislation, what we would then have to do is not communicate that to the client who has now come into our centre, but we would have to go back to the doctor because this is now a diagnosis that is going to have some impact on whether the person is suitable to enter our program. Possibly the client or the patient would then have to go back to the doctor to be informed of what that diagnosis was. We would have to communicate with the doctor, the doctor then with the client and possibly then we would discuss what would happen. It just seems to be an unnecessary addition or layer, although as Pat pointed out our major concern is in another area. If I have a minute, I would not mind just elaborating on that.

Our centre has been running—we are into our 12th year at the end of November. One thing we have learned, which I think is the most essential thing I have learned at our centre, is that speaking to people with aphasia, communicating with aphasic individuals is not something that comes naturally, either to the lay public or to professionals. We certainly know that, because family members, who are the most motivated and who are with the problem the most, are not expert communicators with their aphasic family members. This is a prime concern to us, that doctors, frequently by their own admission, are not trained in the techniques of getting information into the head of someone who is aphasic, and even more important, making sure they have an opportunity to let you know how they feel. We train volunteers. This is what we do every day. We know it is nothing to do with intelligence. We have volunteers coming from many professional backgrounds, including allied medical professions, who do not know how to do this. That is a major concern for us.

Mr Beer: If I could just follow up on that, because I want to be clear here on the way in which you are working with the doctor and then applying that to the new legislation, at your centre would everyone who comes there at some point in the process have been referred by a physician to the centre or to a speech language pathologist?

Ms Kagan: I could not say whether every person would have been referred by a physician. I would say in the majority of cases.

Mr Beer: The majority.

Ms Kagan: But it is not required for our centre that they be referred by a physician. It is just the practice that most people will have been referred.

Miss Arato: People can come from hospital, because they come straight from the hospital usually.

Mr Beer: But where that has happened, a medical diagnosis has been made by someone. After that having been done, then is what you are doing not in effect what I call the assessment? Even if you come to some different determination in the normal course of your practice, if that differed from what the hospital or a doctor had said, you would go back and say: "Look, I don't understand why you have said A, B and C. It seems to me we should be doing something else."

Ms Kagan: When you say go back and say we do not agree with what the doctor has said, it would be that we have not agreed with what the speech pathologist has said. The doctor will often refer to the speech pathologist but the fine diagnosis is often made by the speech pathologist. Just in terms of scope of practice and areas of expertise, aphasia is a very little understood disorder. Based on our experience, most family doctors really do not have much experience with this disorder.

What you will have if the person has come through a hospital access route is that he will have been seen by a neurologist. There might have been a diagnosis of aphasia, there might not have been. There has presumably been a referral to a speech pathologist. But our information will come from a speech pathologist, and that will include

information from the doctor in terms of where the site of lesion is.

Mr Hope: I was just re-reading the beginning of your brief. You train volunteers to carry out communication programs. Then you go on with title protection, looking at school boards. I guess, using the same formula as you use, that you have people you train to do a job. They are doing it, because you are not directly with each one of them. Yet on the other hand you talk about school boards for title protection. I really do not understand the difference between what your volunteer workers do on the job with the communication program and what somebody may be doing who is in a school board setting.

Ms Kagan: Are you talking about the actual issue of protection of the title in the two different—

Mr Hope: You have brought the protection of the title to us, and at the same time I am looking at quality assurance, where you are having a speech-language pathologist training volunteers. There is a questionable quality assurance issue. Who is accountable? I would like to know that. The other part is that you talk about, on the school board level, using people who may be more inclined to know what is going on than your volunteers. I am having a hard time balancing out those two.

1450

Ms Kagan: I do not know if this will answer your question or not, but our program is a very closely professionally supervised program so that, as I was explaining earlier, all members come in with a full assessment. They are assessed by speech pathologists. There is a lot of interviewing and pre- and post-assessment protocols that are followed. Our training of volunteers is also quite a rigorous, intensive one, closely supervised and closely monitored. It is not just for an economic reason. We have a certain philosophy of care which, if we have time, we could go into.

Speech pathologists form an integral part of their program. We are very aware of quality assurance issues, certainly in terms of things like evaluating the progress of clients who come in. We follow up. We look at changes in communication status as well as social status resulting from work that is being done by volunteers. It certainly is a professionally supervised program.

What I do not understand is that I think the title of "speech therapist" should be protected in any situation where you have a professional person working and where there could be a potential misunderstanding about who is qualified to do that work. Somebody who is not a professional speech language pathologist is not qualified to do what I do at the centre. This is not a job that can be done by a layperson. I do not know whether that answers what you have asked.

Mr Hope: The only thing I bring forward is the confusion to the consumer, the confusion to the people you are treating or helping with the communication program and the people who are doing the volunteer work. I am trying to get a grip, an understanding. You are using the confusion for the consumers with the title protection. Then you

are using volunteer workers. I am wondering if the confusion is also there with your patients.

Ms Kagan: I am not sure whether or not this is the misunderstanding, but possibly what is happening here is that there are certain issues that are of direct concern to us at our centre, communicating diagnosis and one or two of the other issues. This is an area, I suppose, of more general concern. We are making our comments as someone who deals as a speech pathologist, of concern in a more general sense. But you are right, that does not apply specifically to our centre.

Miss Arato: That should be protected, that we are qualified to do that. Our volunteers are not qualified speech pathologists. They are trained by speech pathologists. They work within that setting.

Ms Kagan: Actually, there is something interesting out of your comments, in that I can think of particular instances where volunteers might have told someone else about what they were doing and called themselves speech therapists and had some pretty angry colleagues.

The Chair: Thank you very much. We appreciate your appearing before the committee today. If there is additional information that you think might be helpful, you can always write to us via the clerk.

CLARENDON FOUNDATION

The Chair: I would like to call now the Clarendon Foundation and ask that you introduce yourself for the committee, just for the purposes of Hansard.

Mr McInnes: My name is Ron McInnes. I am a member of the board of directors of the Clarendon Foundation and currently secretary of that organization. This committee has already heard from Vic Willi of the Centre for Independent Living in Toronto concerning independent living for people with physical disabilities and the importance of self-directed attendant services. I believe it has also heard from a representative of at least one organization which provides attendant services to adults with physical disabilities. Clarendon is another such organization and wishes to emphasize the importance of the concerns which have already been raised.

Clarendon is a non-profit corporation which provides attendant services to physically disabled adults in two support service living units, which are usually referred to as SSLUs, in the city of Toronto. The services which Clarendon provides are funded by the Ministry of Community and Social Services. They are provided to men and women living in their own apartments or co-op units, although Clarendon itself is not involved in the provision of housing.

The services of Clarendon's staff are provided on a 24-hour-a-day basis pursuant to a service contract between Clarendon and the consumer. The purpose of Clarendon is to provide the physical assistance required by the consumer to enable him to live independently, to go to school or work or participate in voluntary activities; in summary, to be active participants in the community and society.

I have attached the "Guiding Principles" and the "Mission Statement" of Clarendon to the copy of the presentation that has been distributed.

Clarendon was incorporated in 1974 and began operating one of the first projects in Ontario in 1975. Over the past 16 years, Clarendon has had to be constantly vigilant of escaping what I call the spectre of the medical model in the delivery of attendant services or attendant care, as it used to be known. We do not want to become an institution in the community.

In this context, we were very much concerned with one of the original recommendations of the Schwartz committee. Shortly after the report of that committee, we engaged in discussions with representatives of the Ministry of Health and the Ministry of Community and Social Services, at which time it became very clear that those responsible for drafting that report were not aware of the impact of the recommendations on agencies which supply attendant services to disabled persons.

The provision which caused that initial concern has been essentially carried through into Bill 43 in section 26. The controlled acts set out in paragraphs 5 and 6 of subsection 26(2) would encompass many of the routine tasks performed by attendants for disabled persons under the direction of those disabled persons and required solely because that person is unable to physically perform the act on his own. At Clarendon, we have never regarded such tasks as being health care services and our staff has been providing them regularly since 1975. However, since there is no definition of the term "health care services" in the bill, we must be concerned that our foundation and its employees may in the future be subject to the very serious penalties provided for in section 36 if these activities are not clearly and specifically exempted from the proposed legislation.

We presently have a situation in this province where a number of SSLUs and outreach programs, which provide similar services to disabled persons in their homes, feel they must refuse to provide certain types of assistance to disabled persons because they, or in many cases their insurers, feel the task is medical in nature and only to be performed by a health professional. Bowel evacuation and catheter procedures are the most obvious examples, but there are others.

Without a specific exemption, Bill 43 will only reinforce this misconception and thereby limit the independence of disabled persons by taking away their right to determine the extent and timing of the services they require and put severe restrictions on their lifestyles. It will also unnecessarily subordinate provision of these routine services to the control of a health professional. For organizations such as Clarendon, costs could very well become prohibitive, and the difficulties of scheduling services around the availability of a health professional would be insurmountable.

We are dealing here simply with routine living functions for persons with disabilities. Some of these differ from what is routine for persons without disabilities; others do not. However, the only difference of substance in our submission is that the person with the disability requires assistance from another person who acts at his request and under his direction. It must be made clear that this bill will not interfere with that relationship. The control of

these services by the consumer is sufficient. External medical regulation would be both intrusive and inappropriate.

A commitment has been made to create an appropriate exemption through regulation. While it may be necessary to spell out some details by regulation, persons with disabilities and the agencies providing attendant services feel strongly that their primary concern must be addressed in the legislation itself.

1500

Accordingly, the Clarendon Foundation would like to add its voice to those requesting that this committee recommend an amendment to Bill 43 to include an exemption for acts which might otherwise fall within the definition of "controlled acts," where they are performed in the course of providing physical assistance with routine activities of living to persons who are physically unable to perform them by themselves. The amendment should provide for an exemption to subsection 26(1), which would apply to acts otherwise falling within paragraph 5 or 6 of subsection 26(2); would apply to the routine activities of living of the individual requiring the assistance, and would relate to physical assistance provided at the request and under the direction of the consumer.

Thank you for your attention.

Mr Hope: Your concerns have been echoed a number of times, and I am sure the government itself and the previous government had no intention of making sure the disabled community would be a victim of the legislation dealing with attendant care. I know there were a number of conversations. Listening to you present your brief today, I understand you want it clear, without any interpretation for the hands of the interpreter. You want clear language put forward after the fights you have gone through all these years. You do not want to re-encounter that fight so you want clear, definite language about attendant care being exempted from the health regulations.

Mr McInnes: That is true, yes. The concern about leaving it for any regulation is that it would mean the control and the obvious restriction, which is there on a plain reading of the act, would be in existence and we would not know what the exemption might state or when it might come into effect. I think the people and the agencies affected by this are very much concerned at this stage. This is a very strong wish, as I am sure you have heard, and I do not think it is a difficult task to make this a very clear exemption within the act.

Mr Hope: Say, for instance, it was not part of the bill and went to regulations, do you feel there may be a battle for the disabled community that then would have to talk to the professions to make sure their concerns were in the regulations?

Mr McInnes: I think at this point there have been a number of discussions with the concerned health professions over this particular issue, and I think tomorrow you are going to be presented with some wording that has been worked out between those professionals and some of the agencies and individuals concerned. I do not think it is a difficult task, I do not think it was that difficult to arrive at

this wording and I do not think it would be that difficult to put it into the act.

Mr Beer: It follows along there and presumably that wording would find its way into section 28, where the other exemptions to the controlled acts lie. Would you still see, with whatever wording came up, there would be a need for regulation as well, or some further interpretation? In your mind, is there a definition of the term "attendant services" that is sort of whole and complete within itself or would there still be a need for some more specifics with that?

Mr McInnes: In my mind, I would say there would not be a need for it. Others may disagree, of course. It depends on the wording of the exemption. The wording as I see it and as I think it will be presented to you will not make use of the words "attendant services" and therefore it will not be necessary to define it.

The Chair: Thank you very much for your presentation before the committee today. We appreciate your taking the time and I know you are aware that if there is additional information you think would be helpful to the committee, you can communicate with us in writing at any time.

CANADIAN HEARING SOCIETY

The Chair: I call the Canadian Hearing Society. Welcome to the committee.

Mr Morrice: Thank you, Madam Chair. My name is Denis Morrice. I am the executive director of the Canadian Hearing Society. With me is Joan Beattie, a senior manager for the Canadian Hearing Society. She is really here to keep me on track and probably to answer a lot of the questions I will not be able to answer.

My first comment is thanks for the opportunity to present to the hearings, but I guess I want to say, where were you 15 years ago when we really needed it? So much has happened in the past 15 years. A lot of changes and a tremendous number of improvements have happened. We really needed it a long time ago. Services to deaf and hard-of-hearing people in Canada—for all the MPPs here, just so you know—are a disgrace. We have been in a continual state of transition in terms of hearing aids and testing for the past 15 years and I hope the legislation is able to look at the year 2020 in terms of what we really want for the future.

The Canadian Hearing Society provides services to deaf and hard-of-hearing people and we have provided the most comprehensive services in North America. We have doctors, audiologists, technicians and counsellors. I have always said we are the best consultants in the country, not because we can suggest to people what they should do, but because we have really tried it and have made a lot of mistakes, so I think we can give a lot of input to people.

Our mission statement for members is that we are there to meet the needs of deaf and hard-of-hearing people as those needs are identified by deaf and hard-of-hearing people. I say that for the reason that the Canadian Hard of Hearing Association presented to you last week, I think, and because our mandate is to support the consumer groups. That is where our position would tend to lead us.

In 1986 Mr Alan Schwartz suggested we do more consultation with the various stakeholders, and to that end in 1986 we met with every single official professional organization and every consumer group, held open forums and attended every North American conference on hearing loss. What we were trying to do was glean from that suggestions and comments that could be made for the upcoming legislation, so I hope the comments I can make now will help. It is really based on all our communication and discussions with the various groups.

I would first like to put it into a bit of a historical context and I think it is only fair that all of this be put in a historical context. That is why my opening statement about the 15 years is pretty relevant. It was not that many years ago that European manufacturers dumped their hearing aids in Canada. They were hearing aids that did not meet manufacturers' specifications. That is simply because Canada did not have a standard for hearing aids. Also, manufacturers gave free trips. It is like, "Sell a couple of more hearing aids and you get the next trip to Sweden." With hearing aid dealers, any one of you could set up a business and start selling hearing aids. It was door-to-door salesmen, 30,000 flyers distributed in a community and then set up in a hotel room. It was really left to the reputable hearing aid dealers to carry on the service for those people.

Audiology is a very young profession. It was not many years ago that there was not a single audiologist in Canada. The Canadian Hearing Society hired one of the first audiologists. But along came this new profession when it was very clear what doctors were doing, what hearing aids were doing and what the role of audiologists was and then audiologists starting dispensing hearing aids, which caused a great confusion in the professional communities.

1510

We then go on to doctors. Most GPs, in terms of their training—I am sure you have heard it before—receive little training on hearing loss. Most ear, nose and throat doctors are nose and throat. That is where the surgery is. It is not on the ears.

In terms of equipment, it was not many years ago—we are talking about really archaic equipment compared to today. We are talking about probe tube mikes, etc. The level of sophistication has expanded tremendously. We were talking about a body aid not many years ago. Now we are talking about canal aids in the ear, behind the ear, FM systems, infrared systems and programmable hearing aids. That level of technology has advanced tremendously.

Along with that, during this transitional period, came the assistive devices program. ADP was the largest significant factor that created that level playing field—a little bumpy, but certainly a level playing field for everyone—and sorted out a lot of what was going on or what was wrong with the system. On top of that there was this Minister of Health in the previous government who created an Advisory Committee on Hearing Aid Services, which once again went beyond ADP to say: "Someone has to look at this. Someone has to take a damned good look at it. It's too complex."

We had another Minister of Health way back called Frank Miller. Mr Miller did what I think a lot of people do

in trying to look at an area. He set up a task force to look at the roles and scopes of audiologists, audiometric technicians and hearing aid dealers, and a report was done and no one got to see the report. The reason no one got to see the report was because he realized it was so complex. But the Advisory Committee on Hearing Aid Services that was established involved all the stakeholders. They were able to stand back and take a good look at it and they are dealing with all the problems, a very difficult job, where every one of the stakeholders is there. They are dealing with the issues.

Today, in terms of the legislation and the act itself, I hope it is not looked at in terms of the specific regulations in isolation of this historical context and what is happening and all the good things that are now happening. The Canadian Hearing Society went into the hearing aid business a number of years ago, in the late 1970s, because of its concern. Within three years we were the largest single distributor in Canada. We went with a three-tier system to guarantee a professional service and to make sure the cost of hearing aids was the same right across this province. Our board of directors recently passed a policy that it supports the three-tier system and that it understands there will be exceptions, be it the rural communities, nursing homes or whatever and that they would have to be identified at some point. The Canadian Hearing Society services have been referred to by many people as a Cadillac kind of service.

I would now like to deal with a few points and one is access. When you look at some of the statistics, per 1,000 population in the urban areas, we are talking about 1.1 people getting service. In rural communities it is 0.3 per 1,000 people. There is an access problem. I do not care how you cut it, there is an access problem so there is a concern on that.

The other point I would like to make is on training. The Advisory Committee on Hearing Aid Services developed exams and administered those exams, but it was really for grandfathering of non-audiologist authorizers. I would just like to make the comment that should your committee decide to go further with that, beyond grandfathering, you should definitely look at a two-year official community college program if you are going to do that.

The third point is really dealing with risk of harm. It is really a difficult one in this field. The major focus has been on a hearing aid being too powerful and how that would be damaging. For an adult, one would say that a person can lose more hearing, that it causes headaches and that there is stress attached to it and so on, but one cannot help but think that as an adult one would simply turn it down. But for children there is no question that there is risk of harm. When a child is born with a hearing loss, language development is imperative and there should be ongoing monitoring with audiologists playing a major role. So there is certainly a risk of harm with children.

Now I would just like to deal very quickly with some of the points with the specific regulations. Then we may even have a longer break. Again, I would just like to bottom-line it by saying that the Canadian Hearing Society supports the consumer groups, but on that there is the

protection of title. Before I go to protection of title, I am saying this with the full understanding that ADP and the Advisory Committee for Hearing Aid Services will stay in place, because that is the real protection.

On protection of title, we support the Ontario Association of Speech-Language Pathologists and Audiologists in terms of the protection of title for audiologists, speech pathologists and speech therapists in all settings, wherever they function.

Conveyance of a diagnosis has to be clarified, and I am sure you have heard it with every other profession. The concern clearly cutting through it is that audiologists and hearing instrument practitioners are concerned that they will not be able to convey the results of their tests to their patients. They are the people who are trained. Doctors are not trained to do that. I am sorry; they are just not trained to do it. On top of that, it is costly and very time-consuming. It certainly would not be in the best interests of the consumer.

However, in its definition of "diagnosis," if it is really an assessment that the professional can communicate, then fine, but those professionals, those audiologists and hearing instrument practitioners, must be able to convey what they have found in their results to their patients.

Prescription: This is more complicated now and it is because I did not really understand what you meant by "prescription." If it means that the profession would simply say, "Yes, you need a hearing aid," which is basically a generic kind of assessment, then we would support that doctors or audiologists would be the ones to do the generic kind of assessment. This is for the obvious medical reason: to make sure that nothing else could be done for that person. The person would then be seen by an audiologist or a non-audiologist authorizer for a hearing aid evaluation and a proper hearing aid selection.

Under that generic fitting, if that is what it means, we would also say that prescription should hold for the consumer so that he can go and get an extra aid, a backup. Many hard-of-hearing people want a backup hearing aid. Many people want a second hearing aid. Why should they have to go back through the whole system again? So we are saying that prescription should hold for them unless there has been a very significant change in their hearing loss, which may mean that something has gone wrong medically. That is if it means a generic assessment in terms of diagnosis.

If the prescription means a very specific type of aid, we are into a different ball game. Then, as far as I am concerned, doctors are not qualified to do that. It is very complex circuitry. The field is changing all the time and with all the doctor's other responsibilities, it is not fair to a doctor to load him with those kinds of expectations. So the right to prescribe should be given to audiologists and qualified non-audiologist authorizers.

Under that system, this would be with the understanding that there would be a doctor's medical examination. Under both those systems, no matter how you clarify the legislation, we must ensure that the consumer is protected, that the consumer is seen by two hearing health care professionals, and that there be no mutual

financial benefit to these two professionals. That is as clear as I can get.

The Chair: We appreciate the excellent presentation before the committee.

1520

Mr Martin: It was a good presentation and very encompassing. I do not know if you know or not, but Gary Malkowski, our colleague, is normally on this committee. He is not here now because he is on the select committee on Ontario in Confederation. I am trying to imagine what he would ask you in light of this legislation and in light of your role out there as an advocate on behalf of the group he belongs to. In terms of the deaf and hard-of-hearing, how would this legislation impact their ability to get what they need to participate fully in society?

Mr Morrice: For the deaf person it would be an interpreter. They would need an interpreter to see the doctor, to see the hearing instrument practitioner, to see the audiologist, or we would ask that those professionals be fluent in sign language. At the Canadian Hearing Society, many of our audiologists are fluent in sign language so that is where deaf people would tend to go. The issue for a deaf person would really be interpreting services. This month alone we turned down 400 assignments in Toronto alone of deaf people asking for an interpreter. That is the issue for deaf people.

Mr Martin: So we could put the best legislation possible in place, but if you did not have an interpreter for this deaf person to access it, you might as well be whistling in the wind. Is that what you are saying?

Mr Morrice: Yes. The issue in this legislation is really hard-of-hearing people. That is really the focus and that is what I think Gary would probably be saying, that this is really a hard-of-hearing issue as opposed to a deaf issue.

Mr Beer: I was interested in your comments about the assistive devices program and the advisory committee. I think you said at one point that however this legislation goes forward, it is critical that the program remain and that the committee remain. I just wondered if you could comment a bit on how you see that program and that committee fitting in with the new structure that would be set up, the council and so on, for the speech-language pathologists and audiologists, because clearly I think there would be a need for some kind of linkage there. How could they be supportive of each other?

Mr Morrice: I think ADP is, by default, governing all the regulations for the provision of hearing health care services and I think they have been doing a terrific job. In terms of the Advisory Committee on Hearing Aid Services, it has pulled all the stakeholders together, developed exams, and whether people like it or not, is forcing all those stakeholders to communicate. It is a complex field and this whole field is going to keep changing. This is not a static field. My goodness, something has to be there to keep these people moving together. They will come out with the policies and the regulations together.

Mr Beer: You see that council, the advisory committee, in effect having a more direct impact on all of those providers than, say, the council would have, because it would be more limited in terms of exactly who it was dealing with. So the protection of the public becomes critical for the work of the advisory committee.

Mr Morrice: Yes.

The Chair: Thank you for your presentation before the committee. We appreciate your coming forward today and I know you are aware that if there is additional information you think would be helpful to committee members, you can communicate it with us in writing via the clerk.

ONTARIO HEAD INJURY ASSOCIATION

The Chair: I would like to call the Ontario Head Injury Association. Welcome.

Mr Roberts: Good afternoon, Madam Chairperson. My name is Bill Roberts. I am the senior manager of policy and development with the Ontario Head Injury Association. The Ontario Head Injury Association is a consumer organization that advocates on behalf of people who have sustained traumatic brain injuries and the people who live with those effects, which includes their family members.

The Ontario Head Injury Association therefore really looks at this legislation from the viewpoint of how it affects consumers. We do not set ourselves up as experts in the field of rehabilitation or as experts in terms of looking at the legalities of this new proposed legislation. However, our professional advisory committee was quite concerned when this new Regulated Health Professions Act had its first reading.

The Ontario Head Injury Association, through the members of its professional advisory committee, has reviewed the Regulated Health Professions Act. Through this group, we view the government of Ontario's intent to broaden the protection of the public as admirable. We applaud the proposed increase in appointment of public members to the advisory councils of the various professional colleges.

However, we are convinced that the proposed legislation contains some serious flaws, because the objectives will not be achieved through this proposal as it is written. We maintain that protection will be narrowed if this legislation is passed as presented.

The Health Professions Legislation Review, as you well know, undertook its work in 1982. In 1989 a final report was produced, with the purposes of the proposed legislation declared as to produce a better regulatory system for health professions in Ontario by giving governing bodies the power to regulate their professions more effectively and by making self-regulation of professions more accountable to the public and more open to public scrutiny, to provide better public protection and to respect the consumer's right to choose his or her health care provider from an array of safe alternatives, and finally, to permit more efficient and cost-effective delivery of health care services.

With respect to these objectives we have reviewed the proposed legislation and determined that there are numerous problems with the legislation. Specifically we have

identified four major problem areas that will impact persons who live with the effects of traumatic brain injury. We list the problems below, then suggest potential solutions.

The first problem is that in the attempt to produce a better regulatory system for health professions, this legislation inadvertently could deregulate many professionals who practise in non-health care settings. In sections of the profession-specific acts which refer to the use of restricted titles, there is reference to providing "health care to individuals." This definition, we believe, is too narrow. Consider, for example, a speech-language pathologist who works for a school board. Under the proposed legislation this professional would be deregulated because his or her position would not provide "health care to individuals." Many similar instances can be presented for other professions such as psychologists working in the fields of education, corrections, community and social services and industry.

For the individuals and families of our association, there are already too few trained regulated professionals in the health care field who demonstrate an understanding of the sequelae of traumatic brain injury. Encouraging the deregulation of professionals in these other human service areas would further exacerbate this situation.

The second problem we have with the legislation is that by only restricting the title of "speech-language pathologist" the legislation could have unintentional consequences. "Speech therapist" is used interchangeably with "speech-language pathologist." Protecting only "speech-language pathologist" and not "speech therapist" when the public uses these terms interchangeably would lead to confusion. The use by other persons of the term "speech therapist" would suggest to the public that they have the qualifications of a speech-language pathologist, when in fact they may have other qualifications.

The third point we have problems with is that the holding-out provisions of the various professional acts are too narrow in definition. Unqualified individuals may infer that they have qualifications which they do not possess. One such example is the term "psychologist," which could be compromised by a title such as "counsellor in psychological services" or some other misleading description. In this situation the consumer would not be able to differentiate who was in fact a qualified member of the professional college. The public needs to be protected from people using descriptive terms which lead to confusion in determining who has received training and is a member of the appropriate professional college.

The fourth area with which we have a problem is that although this proposed legislation attempts to protect consumers' rights to select safe alternatives of health care, the legislation, as it is written, has unnecessarily created an inefficient system through the controlled acts section, paragraph 26(2)1. This paragraph states: "Communicating to the individual or his or her representative a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her representative will rely on the conclusion."

This paragraph creates the likelihood that a professional such as a speech pathologist, speech therapist, occupational therapist or physiotherapist who carries out an assessment and analysis will be unable to share this information directly with the patient. Not only is the time delay assumed by waiting for a doctor or psychologist to share this information unacceptable, but the cost incurred through double billing to the health care system is unnecessary. We perceive this proposed arrangement to be a new barrier to receiving effective and efficient health care for persons with traumatic brain injury.

Our proposed solutions to the problems are as follows:

1. We suggest that the phrase "health care to individuals" be replaced with "professional services to individuals" in the profession-specific acts or that the reference to "health care" be deleted. This revised phrase would not exclude qualified professionals in other human service areas such as education and community and social services or industrial settings under the legislation. For the above-noted reasons, we believe the consumer will be better protected.

2. We suggest that the title "speech therapist" as a restricted title be included in Bill 44, the Audiology and Speech-Language Pathology Act.

1530

3. We suggest that to resolve the narrow definition of the holding-out provisions, the various professional acts be amended to read:

"No person other than a member may take or use any name, title, description, variation or abbreviation in any other language implying or calculated to lead people to infer that the person is qualified or recognized by law as a member of the college of"—the appropriate college.

4. We suggest that the controlled act of diagnosis as written in subsection 26(2) of Bill 43 be revised to ensure that professionals such as speech-language pathologists, speech therapists, occupational therapists and physiotherapists can communicate their findings directly to their patients.

That is our very brief presentation.

The Chair: We appreciate your excellent presentation.

Mr Hope: First of all, thank you for making the presentation. I know your organization works for a lot of people, because I have had the opportunity of working with yours quite a bit.

When you brought forward the title issue, do you see a lot of problems with the current way the legislation is proposing? Do a lot of people say they have been misled, especially when you are dealing with people with severe brain injury who may be left out in the cold and not sure so they are grasping at whatever?

Mr Roberts: Yes, I think that is probably accurate. Certainly people with serious cognitive problems can be very easily misled, and I think that, for instance, there are individuals sometimes who are seeking psychological services, particularly neuropsychological services, and are quite susceptible to being very easily misled by someone who is using a descriptor. Someone who calls himself a counsellor in psychological services could be quite mis-

leading to a person with a brain injury, and certainly to a family that is in a great level of distress, and that seems to characterize most of the families we deal with. They are often just looking for any kind of solution to a problem and it would be very easy for some person to describe himself or herself as having qualifications and extracting a fee when in fact he or she could not provide much assistance at all.

Mr Hope: Dealing with your first proposal about the professional services to an individual instead of health care, could you just elaborate a little more? You had me confused on that, especially when we deal with the social worker aspect of things.

Mr Roberts: I guess what we are trying to get at here is that in the very narrow definition of "health care" there are so many services that are being provided to people with traumatic brain injury in other kinds of settings, such as education. Unfortunately, some of our membership end up in the Correctional Services system and so forth, and by really just trying to focus on health care and trying to define health care, we think that could create a whole kind of conundrum for people trying to access service in other kinds of settings. There could unwittingly then be people who are providing services without proper qualifications because they are not covered under this legislation.

Mr Hope: Your proposals reflect your clientele because they may end up in the correctional facilities or through the Ministry of Community and Social Services, so you are mainly focusing on putting this wording on your own clientele that you deal with in making sure protection is there for them.

Mr Roberts: We are interested in changing the reading of the act to delete that notion of it just being in the health care services provided in the health care field. Is that clear?

Mr Beer: One issue you do not refer to here, and I just want to make sure what the position of the association is on it, is the point that was made previously this afternoon around attendant services and the concerns that have been expressed by a number that there be an exemption for those services to be provided by an attendant care person. Can I assume that your organization would want to see something such as that for attendant care workers?

Mr Roberts: Actually, that did not come up in any of our discussions, so it would be unfair for me to comment on that. The position I have here comes from the committee. Otherwise, it would just be a personal opinion, so rather than comment on that, I will just—

Mr Beer: Sure. That is fine.

The Chair: Thank you for appearing before the committee today. We appreciate your presentation, and I know you are aware that you can submit any additional information in writing to the committee at any time during our deliberations.

ONTARIO ASSOCIATION
OF DISPENSING OPTICIANS

The Chair: I would like to call next the Ontario Association of Dispensing Opticians. Welcome.

Miss Raymond: Thank you for allowing me the opportunity to speak with you this afternoon. My name is Pat Raymond. I am past president of the Ontario Association of Dispensing Opticians. Currently I am still with the association in the capacity of vice-president and director of legislation. I have been working from the review stage through the current proposed act for the past four years.

Having studied the Regulated Health Professions Act in great detail, the Ontario Association of Dispensing Opticians, with the consensus of the Ontario Contact Lens Association and the Board of Ophthalmic Dispensers, Ontario, would like to discuss with you the need to include a definition of "dispensing" as it applies to subnormal vision devices, contact lenses and eyeglasses. In addition, if time permits, we would like to express our concern with the delegation of controlled acts and possibly some of the authorized acts, but in particular our concern is with the omission of a definition of "dispensing."

The Ontario Association of Dispensing Opticians is proud of the quality of eye care currently attainable in this province. This is due in part to the high quality of standards placed upon the education of opticians and in part to the fact that within our current regulations under the Health Disciplines Act there exists a concise definition of "dispensing." With this definition, our regulating body, the Board of Ophthalmic Dispensers, has been able to successfully charge and prosecute non-members of this profession who engage in ophthalmic dispensing.

We urge you to consider seriously including a definition of "dispensing" in the new Regulated Health Professions Act, 1991.

For the purpose of section 4 and subsections 26(2) and 26(9), the Ontario Association of Dispensing Opticians, the Ontario Contact Lens Association and the Board of Ophthalmic Dispensers, Ontario, agree that the following definition of dispensing is necessary for the administration and enforcement of the Regulated Health Professions Act and the accompanying Opticianry Act.

"Dispensing means:

"(a) interpreting a prescription for;

"(b) evaluating or advising a person in respect of; or

"(c) preparing, providing, verifying, adapting, fitting or duplicating a device for subnormal vision, a contact lens or eyeglasses."

According to the New Lexicon Webster's Dictionary, there is a simple definition of "dispense," which is to distribute or to hand out. This application's result would be that all interpretations and evaluations, measurements and lens designs, fittings and adaptations required prior to the final handing out of the appliance could be performed by an unregulated person.

Many considerations and variables must be taken into account before a prescription can be effective. To simply manufacture an appliance and ensure that it meets the parameters of the written prescription would be a disservice to the patient and for that matter to the prescribers.

For example, in our definition we are requesting the word "interpretation." To effectively interpret a prescription, an optician must consider the following aspects:

First, the power of the lens: In many cases the optician must compensate the written power of a prescription to effectively satisfy its requirements. For example, as a lens is moved away from or closer to the eye, the power of the lens is effectively altered. The optician can calculate for differences in lens placement in relation to the actual refraction distance. With this information, we can determine the power needed to effectively produce the power prescribed.

To make that simple, everybody here looks like he had a pretty normal childhood, and I do not think there is anybody here who has not tried to burn an ant hole or a piece of tissue with a magnifying glass, or at least watched somebody do it. The whole idea of taking the magnifying glass is to collect bundles of light and bring them to a point focus on that piece of tissue or leaf or ant hill and try to start a fire. If you can recall, if you were one of those kids who did it, and I am sure you are, you would bring the light to a point focus. There was a certain point where the light would become very sharp. If you held it there long enough, you would get a flame. If you took that magnifying glass and brought it a little closer to the object or a little farther away from the object, that point of focus dispersed and you could stand there all day and not get a little bit of a flame.

1540

Eyeglasses work on much the same principle. We are gathering bundles of light to pass through the lens to bend that light so that the ray will fall right at the retina. If we move those lenses away from or closer to the eye, we are effectively changing where that point of focus will be, just like the magnifying glass.

An optician is trained to take that into consideration, to take the prescription where the doctor's instruments have made it a certain distance from the eye. If the new glasses are going to fit farther or closer than that distance, we can calculate a power of lens to order different from the prescription but which effectively gives us the same power as it relates to the distance from the face. That is one of the reasons we need this interpretation and this definition put into our particular act.

The frame position will also make a difference, like varying the distance the lens sits from the eye. Changing the angle at which it is placed in front of the eye, or the pantoscopic tilt, will also affect the power of the lens. This will cause an aberration in sight which is known as oblique or marginal astigmatism. If, to ensure a comfortable fit, we must change the angle of the glasses, we in effect are changing the effect of the prescription. Again, we must compensate and calculate a power that will effectively give us what the doctor has written on the prescription. Left uncompensated, both of these examples would result in reduced acuity, distortion, eye strain, headache, nausea, lack of depth perception and in some instances double vision.

Another concern we have to take into account before a lens is even ordered is the base curve of the lens the patient was wearing previously. The base or the initial curve of the spectacle lens determines the amount of magnification that will be induced by the lens, separate from the prescription.

A single power or a single prescription is available in several different base curves. To just arbitrarily supply lenses without taking this into consideration can result in adaptive difficulties, such as loss of depth perception, reduced eye-hand co-ordination and headaches.

In the second part of our definition, we request the wording "prepare and provide." Once the prescription has been interpreted, measurements are taken to accurately design and prepare an appliance. The placement of the eye, for example, must be measured both horizontally and vertically within the parameters of the lens opening of the frame. It is imperative that the optical centre of the lens—this is where the light ray travels at the straightest line—will align exactly with the point where light enters the eye. To deviate from this point at all, we get what is called a prism effect, which again can result in double vision and disorientation. I have included a list of some of the measurements that we do take in fitting eyeglasses and contact lenses. I will not read them now.

We would also like to see "duplication" included in our definition. The duplication of a pair of glasses or contact lenses is not merely the copy of the dioptric power, that is, the lenses, given to us. Even if only one lens is being replaced on a pair of glasses, we have to take into consideration the base curve of the original lens, the optical centre placement and the decentration so as not to induce uneven magnification between the two eyes, so we will not have one image coming bigger than the other, which again will cause a double vision or imbalance. This will also cause a prism effect. We have to watch for all of these things.

In the case of contact lenses, the fitter would be terribly remiss not to assess the current lenses and take new measurements. Corneal changes, as well as other factors, would result in the necessity to redesign the lens. Not to do so would put the patient at risk. Even minor adjustments necessary to the design, left uncorrected, can result in corneal ulceration, vascularization or corneal infection.

The final verification, that the prepared appliance meets all the criteria of the design ordered, that it is carefully conformed and modified to satisfy the intent of the prescription and is fit comfortably on the patient, requires the expertise of a trained professional. An improper adaptation or fitting of a pair of eyeglasses would undo all the careful steps taken by the optician to measure, design and prepare the appliance. A poorly adjusted frame, in addition to the more obvious physical discomfort, can cause visual anomalies due to incorrect angling, nose pad adjustment or slippage resulting from improperly adjusted temples. Even marginally incorrect fitting or adapting of a contact lens would result in aberrations and ulcerations leading to infections, and all leading to possible loss of sight.

From these examples, which list only a fraction of the information and background knowledge necessary to competently dispense a prescription for subnormal vision devices—contact lenses or eyeglasses—you can appreciate that there is considerably more involved in the dispensing of an optical appliance than the mere handing out of the completed product.

The members of the Ontario Association of Dispensing Opticians do not believe it is the intent of the Ministry of Health to indicate that these imperative steps of dispensing be unregulated, and we urge you to include a definition. Without a defined outline of the parameters of dispensing as it applies to this profession, the College of Opticians of Ontario, currently known as the Board of Ophthalmic Dispensers, Ontario, will be unable to effectively enforce the regulations or prosecute non-members for the protection of the public.

As this committee may already be aware, opticianry is a highly retail health profession, greatly influenced by large corporations. Within the Health Disciplines Act and the accompanying Ophthalmic Dispensers Act, there currently exists a definition of "dispensing." With this definition, both the optician and the corporation are clearly aware of the boundaries surrounding the regulations affecting ophthalmic dispensing. With this definition, the licensing body has been able to effectively regulate the profession and successfully prosecute those who illegally step within its bounds.

As can be expected, a provincial court judge must rely heavily upon the wording of the law and how it applies to the charge. Using our current definitions, the board has been capable of bringing charges against those companies and individuals who have practised opticianry without respect of regulation or law. Also using this definition, the board has been successful in relating the charge to the definition, thus allowing the judge to fully understand the infraction. Might I add also that the board has seen a 100% success rate in convictions for every case brought before the courts.

We at the association do not believe this could be possible without a definition of "dispensing." A judge, not knowing the intricacies of the profession, would rely heavily upon the known definition of "dispensing"—to distribute or to hand out—should no other exist. Without a prescribed definition, large companies, which already dominate the industry, will reduce their regulated staff and keep opticians to a minimum, for the sole purpose of the final distribution of the product, and replace them with lower-paid unregulated persons. This is already evident. It is being tried in the province. That is why the Board of Ophthalmic Dispensers, Ontario, spends so much time in court. Without a definition, court time would be useless.

It is our fear that with no definition to rely upon, the regulating body will no longer be successful in its enforcement of our regulations and that the calibre of care currently achieved will be reduced to a commodity, with little or no concern for visual quality. So that is our greatest concern at this point, that a definition be added to the act.

If I have time, I would like to very quickly mention "delegation of controlled act." We are quite concerned with the wording of section 27, which states:

"(1) The delegation of a controlled act by a member must be in accordance with the regulations under the health profession act governing the member's profession."

"(2) The delegation of a controlled act to a member must be in accordance with the regulations under the health profession act governing the member's profession."

1550

As much as we are aware that those issues are going to be covered during the regulation-making process, we feel it is noteworthy now. We feel that subsection 27(1) leaves too broad an opening for unqualified persons engaging in controlled acts. The implications of delegation to unregistered persons are already surfacing within the optical industry. In recent years there has been an increase in medical practitioners refracting. With little or no practical optics or dispensing experience, the delegation of spectacle dispensing has been given to unregulated assistants. For the reasons specified in our request for a definition of "dispensing," many of these patients are being fitted with glasses with little or no emphasis placed on interpretation, evaluation, design or adaptation.

I was unfortunate enough, I guess, to recently have a patient referred to me by an ophthalmologist. She had been examined by a medical practitioner and a prescription was given to her for eyeglasses. She was in turn sent next door to the consultant to have eyeglasses made. After picking up her new glasses, she experienced extreme peripheral distortion, reduced field of vision, lack of depth perception and severe headaches. She returned to the optical dispensary and discussed her problems with the consultant, who, by the way, the patient erroneously assumed was an optician. She took for granted this was an optician.

Not having had any training or education in physics or practical optics, the consultant was limited in her ability to troubleshoot the situation. She determined that the lenses had been made correctly to the doctor's prescription, could find nothing wrong and sent the patient back to the doctor. The doctor re-examined her and said: "No, that's the prescription I want. That's the prescription you got. You'll be fine." She went back to the consultant, who told her: "Give it a little time. You have to get used to the new prescription."

Two weeks later she was back at the dispensary. Her headaches were worse but the distortion had gone down a little bit. The assistant again said, "Look, the glasses are right. That's what the doctor ordered." To make a long story short, they sent her to her family physician because they told her it had to be a physical problem. By the time she got to a doctor, she was sure that she was dying, that she had a brain tumour. The doctor could find nothing wrong and sent her to an ophthalmologist, who could also find nothing wrong.

It turned out that it was simply a lack of interpretation for the prescription to the appliance. We made her new glasses in the identical prescription and she is fine today, but she went through hell for almost a month and a half.

There are two very important issues derived from that case scenario. One, the unfortunate individual could have been saved a great deal of physical, mental and visual anguish if she had been fitted by someone who was trained in the art of opticianry. Second, visits to three doctors, two of them more than once, and a host of lab tests were all billed to the Ontario health plan, all needlessly and all at the expense of the Ontario taxpayer.

I will be quiet now.

Mr Beer: If I might, a question to the parliamentary assistant: In the brief it is noted that the Health Disciplines Act and the Ophthalmic Dispensers Act contain a definition of "dispensing." I was wondering if it was considered to place that as well within section 26, and if there was a reason why that was not done.

Mr Wessenger: I will ask counsel to reply to that.

Ms Bohnen: The review was asked to place a definition that would more or less be the same as the current definition in the Ophthalmic Dispensers Act into the new legislation, and thought it inappropriate to do so. You might want to explore that more fully with Mr Schwartz.

Mr Beer: I wanted to just be clear that this had been put forward but the review had decided not to do that.

Ms Bohnen: Yes.

Mr Beer: We can go over that and go over these arguments when we have his testimony.

The Chair: Thank you very much for appearing before the committee today. We appreciate you taking the time. If there is any additional information you think would be helpful to the committee, please feel free to submit it to us in writing via the clerk.

BOARD OF DIRECTORS OF CHIROPRACTIC

The Chair: I would like to call now the Board of Directors of Chiropractic. Welcome to the standing committee on social development.

Dr Burge: Good afternoon, Madam Chair, members of the committee and guests. I would like to thank you for the opportunity to present the views of the Board of Directors of Chiropractic on one of this province's most significant pieces of health care legislation ever. My name is Ted Burge, chairman of the board. With me are Mrs Sylvia Pusey, a public member of the board, and Dr Stan Stolarski, the registrar.

The members of the Board of Directors of Chiropractic are appointed by the Lieutenant Governor. The board is the regulatory body for the profession and has responsibilities in four main areas: prescribing of examinations for the admission of chiropractors to practise in Ontario, registration of those meeting the criteria outlined in the Drugless Practitioners Act, discipline of chiropractors under the same act, and regulation of the profession.

The past eight years have been an exciting and busy period for the board. We have been active participants since the beginning of the Schwartz review. At this time we would like to commend all those who participated in the process since Mr Schwartz made his initial recommendations. I would like to pay a special tribute to Mr Alan Burrows and Ms Linda Bohnen, who have been wonderful people to work with.

Mr Owens: Let the record show applause.

Dr Burge: The support of three governments for this legislation indicates its importance, and I have no doubt that since the hearings began you have heard many others make positive comments about the proposals.

At the outset, I would like to reiterate that the Board of Directors of Chiropractic is supportive of this legislation.

We applaud its goals of public protection and freedom of choice in health care. However, as I am sure you have heard from other submissions, our profession has a concern with the legislation in its current form. We would like to focus on the issue that we consider to be of primary importance to the patients of chiropractors.

We all understand that the Regulated Health Professions Act should to the fullest extent possible protect the public from risk of harm from health care providers and ensure that each citizen may exercise a freedom of choice within a range of safe options.

The board would like to draw to the attention of the committee that the proposed scope of practice contained in the Chiropractic Act includes the treatment of articulations of the spine and non-spinal articulations. The proposals also provide the statutory authority for diagnosis by a chiropractor of dysfunctions or disorders arising from the structures or functions of the spine and their effects on the nervous system. Our board believes this provides significant statutory protection for the patient with respect to diagnosis and treatment of the spine.

However, there is something missing from this scope of practice. I refer to the statutory authorization for the diagnosis of articulations other than those of the spine. This is a specific area of chiropractic expertise, but if the proposals are implemented as is, it will disallow the patients of chiropractors to be informed of a diagnosis of articulations other than those of the spine.

A diagnosis, not an assessment, is demanded by many insurers, employers and third-party interests. The lack of authority for a chiropractor to diagnose these problems will result in added costs to the health care system and will restrict an individual's freedom of choice.

Notwithstanding chiropractic inclusion in workers' compensation, OHIP, veterans' insurance, no-fault insurance and major medical coverage by private and group insurers, it is still a common occurrence for employers, insurance companies, lawyers, and in general third-party stakeholders, including other health professionals, to interfere with the freedom of patients to seek chiropractic care.

Permit me to give you some examples which apply to personal injury, liability and disability claims or, for that matter, any claim by a patient that has to go through a process of adjudication:

1. Chiropractic patients are often required to obtain confirmation of the appropriateness of their chiropractic care from a physician;
2. Legitimate claims by patients for disability compensation are often challenged by the insurer, and chiropractic patients are forced to validate the opinion and care of their health care provider through consultation with a physician;
3. Employees are sometimes directed by their employer to seek other resources for health care and in some instances are directed to discontinue care with their chiropractor.

Many patients are intimidated by fear of reprisal from their employer or the Workers' Compensation Board, and in many instances are just uncertain that their claim will be reimbursed. Despite reassurances, many patients are confused by these demands and forfeit a freedom of choice

which in my view is a hallmark of the legislation we are addressing today.

These patient problems centre around the lack of authority of a chiropractor to state on behalf of the patient a conclusion identifying the etiology of the patient's condition. If the authority were recognized, chiropractic patients would enjoy the advantages.

1600

In these circumstances, the chiropractor and the patient are frustrated. The patient is helpless as a wedge is driven between the chiropractor's responsibility to his or her patient and the patient's need for treatment, and inevitably the patient is the victim.

There is an appendix—although I must add that it is quoted just below this paragraph—attached to this brief, issued by the superintendent of insurance in Ontario. Although this bulletin is slightly dated, nevertheless the concerns are as current and relevant today as they were at the beginning of the review process. In our view, this memo speaks to the seriousness of this problem.

"Because of complaints received, I believe it would be appropriate to review some of the features of this coverage and, in particular, how they relate to chiropractors.... Reasonable and necessary chiropractic expense is covered. There is no requirement that such treatment be prescribed by a medical doctor.... Provided the claim for chiropractic expense meets the 'reasonable and necessary' standard, I would look with disfavour upon any insurer who relies upon these parts merely to frustrate the claimant who sought out such treatment independent of medical consultation."

In practical terms, unjust demands by third party interests under the present system take licence to avoid payment of legitimate patient claims. The system takes advantage of the weakness and the current statutes provide no defence for a member of the public who wishes to exercise the freedom to choose a chiropractor for care when third-party payers wish to exert their power to demand other consultation or withhold payments.

Our board views the absence of statutory authority to protect the patient's right to a diagnosis of these problems by a chiropractor as the root cause. Should the freedom to access the health provider of choice include the risk of finding oneself in a helpless position to defend that choice? We think not.

The Board of Directors of Chiropractic, the Ontario Chiropractic Association and the Canadian Memorial Chiropractic College have suggested an amendment to paragraph 1 of section 4 of the Chiropractic Act which will provide a foundation for the eventual resolution of this problem.

We suggest an amendment that would provide for "the diagnosis of non-spinal articulations." While this amendment is important to the profession if it is to meet the expectations of patients, it is far more important to those members of the public who choose chiropractic care for problems not related to the spine.

In a survey undertaken by the Board of Directors of Chiropractic last August, the public expressed support for chiropractic as a trusted health care provider. The survey showed that 52% of respondents indicated that they or a

number of their family have visited a chiropractor some time in the past. I will add that over 40% of those respondents had direct contact with a chiropractor.

Seventy-two percent of respondents who went to a chiropractor said they were satisfied and 47% said they were very satisfied; 73% believe that in addition to back and spinal problems, chiropractors are also appropriate for problems of the extremities, such as shoulders and knees.

The results of the survey confirm our belief that the public must be provided with a statutory safeguard against the persistent impediment to their access to chiropractic care and third party funding.

Chiropractors are well educated in diagnosis and treatment of articulations of the body, with over 600 hours of curriculum devoted to diagnosis and treatment of articulations other than those of the spine. This is a distinctive aspect of chiropractic practice and is understood by the public to be an option for those who may choose it.

If the proposals are not amended, only one profession of 24 will be authorized to diagnose dysfunctions or disorders arising from the structures or functions of articulations other than those of the spine. If this be the case, the public has no choice. The board views this as a flaw in the proposals. Perhaps this may be understandable if there were only one profession to perform this authorized act, but this is not the case.

We believe that if the proposal remains as it now stands, it will simply maintain the existing barriers to citizens who choose chiropractic care, and we therefore urge your committee to amend paragraph 1 of section 4 to provide for "the diagnosis of non-spinal articulations." I shall be pleased to respond to any questions.

Mr Owens: I do not have a problem in principle with what you are requesting. I do not quite understand, and I ask the parliamentary assistant to chime in and add clarification, why that element, the diagnosis of extremities, was left out. Your profession seems to be doing it with sports injuries. It seems to be doing it in private practice. So why was it left out?

The Chair: Mr Wessenger, you are requested to please chime in.

Mr Wessenger: Yes, I will ask staff to indicate the position of the review.

Ms Bohnen: As we have talked about before, the review's opinion was that the scope of practice recommended for chiropractors was what was appropriate and consistent with the primary function of chiropractors. Also remember that this does not restrict the treatments provided or the assessment capability provided by chiropractors. The only issue before the committee that is being discussed today is diagnoses of disorders and dysfunctions of non-spinal articulations. The issue, as it is being presented to you today, seems to be that chiropractors currently have some difficulty in this area with interference with patients' rights. Of course the legislation is not yet enforced, so you might be interested to explore what is the source of the current problem even before we have legislation, and can legislation reasonably solve this problem?

Mr Beer: This is partly along the same lines, but I wanted to be clear on the current situation with respect to non-spinal articulations. Is there anything that prevents you from doing that today, other than—do I assume some companies do not accept the fact you do that? That was sort of the point of the first section, but in day-to-day practice, chiropractors are doing this. Is it partially accepted? Could you maybe explain how that functions?

Dr Burge: The issue is that chiropractors have always treated articulations other than those of the spine, and do to this day. I think the issue I am trying to emphasize today is that an insuring company will look to an authority to confirm the patient's disability or claim, and oftentimes, it is my opinion and I think it is the experience of the profession, there is a way to work with this thing that allows the companies, in some cases, to avoid payment of claims. We are talking, in some situations, of where it really prejudices the patient's physician.

If someone has been off work for three or four weeks, anticipating a certificate of disability from a chiropractor, and then the insuring company does not accept it because it says, "Where is your authority to make that statement?" I am suggesting that if that is the problem, this legislation should address it. It should give the authority where the patient needs it and the authority is not in the patient's physician's office when the patient has been in the chiropractor's office for three or four weeks being treated. The authority should be with the individual dealing with the patient.

Mr Beer: Under the legislation as it exists today and regulations, is it that this is not clear, or is there a specific clause that says you cannot do this or you should not?

Dr Burge: No. I stand to be corrected, but I am not aware of any specific prohibition against the chiropractor making that authority. But I am equally not aware of a clear-cut authority defined in the Drugless Practitioners Act that says you can.

Mr Beer: As was said by counsel, as presently worded it would not prevent you from doing non-spinal articulations but it would prevent you from diagnosing?

Dr Burge: Absolutely.

Mr Jackson: I appreciate this brief, which is one of several we have received from chiropractic. In this one you talk about third-party interference, which is a very polite way of referring to the compromising effect of this legislative initiative for patients in a variety of circumstances. This is the one that concerns me the most, because, as counsel has made clear, we are dealing with a very narrow range of factors in developing this legislation. We are not really looking at the consequences of the relationship between the patient and some patients' rights issues or access issues. I understand that, but we are clearly going to be causing these kinds of activities to occur as a result of this legislation.

We have received persistent and consistent deputation to the effect that this would seriously affect the help that people are seeking and obtaining very successfully from chiropractors. Do you have any further information with respect to the WCB, or the recent changes in auto insurance

from the previous government, or any cases of complaints that illustrate more clearly the concerns you have raised under the referenced third-party interference? I am familiar as a patient. It happened to me. My physician would not recommend it. I went to the chiro on my own and I received my treatment. Are you receiving—

Interjection.

Mr Jackson: It is a well-known case, former Madam Minister. It is the case of my wrist, since you wanted to hear all about it.

1610

Dr Burge: I think I heard about that.

The Chair: I think it is all on the record, Mr Jackson. We can dispense with more description. I was just being rather cute.

Mr Jackson: I appreciate your raising the specifics of my wrist, but back to the point.

Interjection.

The Chair: Order. I will ensure that the time is added.

Mr Jackson: I have stated my question. Are there any other specific cases that have come to your attention? You are being a little polite here.

Dr Burge: I understand that. You must understand that the mandate we are representing is that of the public interest, but our board does not specifically deal with complaints about the Workers' Compensation Board. I would think, in response to your question, that the best answer I would give you is that I think we should probably sit down along with the association, which does have direct dealings with the Workers' Compensation Board and is more familiar with its function as an organization than our board is. We would be happy to make a submission that would give you further documentation on this if you wish, Mr Jackson.

Mr Jackson: Would you get that before the 16th, when we are meeting with various ministries in our opportunity to raise specific questions about the impact on WCB protocol? It would be helpful to us.

Dr Burge: I would be more than happy to see that is provided.

Mr Hope: This is around the same thing Mr Jackson had, other than that I did not hurt my wrist. I would like to look at the issue of the third party that you are talking about. A lot of the insurance companies are setting up, for instance, with the Workers' Compensation Board. I do not want to throw partisan stuff into this, but the board has its own doctors and still will not give you the right, even though we give you the right here. You still do not have that entitlement because there is still another body over

here that has to approve of it. Even though we do consider what you are proposing today, it is still not going to allow you the access to the third party issue of insurance.

Dr Burge: I think we have to look at this whole process we have been through from HPLR to the present and understand that there is a whole change in the system. I think this legislation provides a foundation for everything that is going to happen from here on. Even to the point, we have been given to understand, that amendments and opening of other pieces of legislation with respect to health care are being more or less, if I can use the terminology put on hold until this is in place. Once it is established that the scope of practice of a chiropractor is that, then as other acts are opened or as other pieces of legislation are dealt with, I would assume a lot of it would be predicated on what has been the established fact in terms of what a defined scope of practice for a profession is. In that sense, I think this is a stepping stone. I would not mean to suggest that this one approach is going to settle 100% of the problems, but it is certainly a foundation stone to settle on. It is part of the process.

Mr Hope: That is what I was going to say. It is just a foundation to maybe open up other avenues, because as we refer to workers' compensation and no-fault auto insurance, you still have another mechanism that you have to go through.

Dr Burge: I understand.

Mr Hope: Even though we can approve it here, it still will not help.

Dr Burge: I am suggesting I think it would be a very big help to us.

The Chair: Thank you very much for your presentation. The committee will look forward to receiving the documentation that you have said you can provide for us. You can do so just by submitting it to the clerk in writing. We will look forward to that. Similarly, if there is any additional information that you think would be helpful, we would appreciate receiving that as well over the course of our deliberations.

Dr Burge: Madam Chair, if I may, I have a letter signed by the Board of Directors of Chiropractic, the Canadian Chiropractic Association and the Canadian Memorial Chiropractic College proposing these amendments that I mentioned in the brief today. I would like to present that to the clerk.

The Chair: That is fine. If you will submit that, it will become part of the public record. The committee appreciates your advice as well as your submission today.

The committee adjourned at 1614.

CONTENTS

Tuesday 27 August 1991

Regulated Health Professions Act, 1991, and companion legislation / Loi de 1991 sur les professions de la santé réglementées	
et les projets de loi qui l'accompagnent	S-671
Ontario Society of Occupational Therapists	S-671
Ontario College of Occupational Therapists	S-674
Canadian Association of Occupational Therapists	S-676
Respiratory Therapy Society of Ontario	S-678
Mary McLelland	S-681
Ontario Teachers' Federation	S-683
Ontario Association of Registered Nursing Assistants	S-686
Carol Kushner	S-689
Speech and Stroke Centre	S-690
Clarendon Foundation	S-693
Canadian Hearing Society	S-694
Ontario Head Injury Association	S-697
Ontario Association of Dispensing Opticians	S-698
Board of Directors of Chiropractic	S-701

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Wednesday 28 August 1991

Standing committee on social development

Regulated Health
Professions Act, 1991
and companion legislation

Assemblée législative de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le mercredi 28 août 1991

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent



Chair: Elinor Caplan
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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Wednesday 28 August 1991

The committee met at 1002 in committee room 2.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

ASSOCIATION OF SOCIAL WORK DIRECTORS OF THE HOSPITAL COUNCIL OF METROPOLITAN TORONTO

The Chair: I want to welcome everyone this morning. I am going to call first the Association of Social Work Directors of the Hospital Council of Metropolitan Toronto.

Mr McNeill: Thank you very much. We represent the Association of Social Work Directors of the Hospital Council of Metropolitan Toronto. Many of you may know that the council represents 50 member hospitals that comprise a number of different types of hospitals including acute and chronic care facilities, rehabilitation hospitals, mental health facilities, convalescent hospitals and so forth.

My name is Ted McNeill. I am the director of social work at the Hospital for Sick Children and am here in my capacity as chair of the association.

With me this morning are Susan Roher, director of social work at Scarborough Grace Hospital; Jane Adams, director of social work at York-Finch General Hospital, and Beverly Abosh, social worker in chief at the Clarke Institute of Psychiatry. There is a brief bit of information about each of us appended to the presentation.

First of all, we want to thank the committee for this opportunity to present our views. We have been looking forward to this and wanted also to make ourselves available to speak with you about the issues that are of concern to us. We also want to commend the government of Ontario, both present and past, including former ministers of health and other key members of the ministry, Linda Bohnen, Alan Burrows and others who have contributed so much to this legislation.

As an association, we are very pleased to say we are in support of the legislation. We are particularly supportive of the underlying principles, the intent of the legislation to protect the public and to offer the consumers within the province a greater choice in health care services. However, we also have some concerns about the way the legislation is currently drafted. As all of you know, social work is not included as one of the professions regulated in the act and will become, when the legislation is enacted, one of the

largest, probably the largest, group of professionals within hospitals that is not regulated. We think this is a serious omission that needs to be addressed.

While social work is not included in the legislation, we feel the legislation as it is written will have a serious impact on the practice of social work not only in hospitals but in other related settings across the province. We agree with the position of the Ontario Association of Professional Social Workers and legal counsel that suggests this legislation will have a chilling effect on the practice of social work in the province. This has to do with the kind of practice we are involved in. As soon as you begin to include mental health within the scope of health care services, you are into what social workers provide, and that is why so many settings other than hospitals may well be affected by the legislation as well.

We do recognize it is not the intent of the government to curtail the practice of social work or to make illegal our practice in any way and we are encouraged by the reassurances that we have had about that. However, we feel we need to speak to the legislation as it is currently written because that is how we feel a judge would be asked to interpret the legislation in a court of law.

What I would like to do this morning is speak very briefly to the role of social work in hospitals, cite a clinical example to demonstrate this and then outline four areas of concerns we have with respect to the legislation.

I will refer now to page 2 of the document you have in front of you, under the heading "Role of Social Work in Health Care," paragraph 2. If there is anything we would like to leave you with regarding the practice of social work in hospitals, it is the notion that central to the role of providing social work services in hospitals is the assessment or diagnosis of the patient's relative level of functioning. Inherent in this is identifying dysfunctional behaviour and the causes or contributing factors that maintain it. While social workers diagnose dysfunctional attitudes or behaviours or relationships, etc, our therapeutic approach is usually to identify strengths and resources and attempt to build on these. However, it is impossible to provide these services without being able to openly communicate our findings with the patient and family. It is this process we believe to be at serious risk under the current wording of the legislation. On page 3 we have identified three examples. I will speak only to the first one.

In paediatric hospitals, such as the Hospital for Sick Children where I am employed, family members often have a very difficult time coming to terms with their child's diagnosis, particularly if it is a life-threatening illness such as cancer or leukaemia. Consequently, they can have a great deal of difficulty responding to their children in the way the child needs, in a supportive and empathic manner. This may be due to many different kinds of causes. The parents'

previous experiences in their own families of origin as well as other personal and interpersonal dynamics may manifest themselves as obstacles to dealing with the strong feelings of fear, anxiety and loss and so forth that get triggered in people in these kinds of situations. Unfortunately, this can be very dysfunctional. Children with life-threatening diagnoses need to be able to talk about their illnesses. They need to be able to talk about their worries and their concerns when they are ready to do that. Otherwise they can feel alone, isolated and become depressed, which becomes then a very serious complicating factor and a reason for concern in and of itself.

Under Bill 43, we believe the social worker on a team could no longer identify the underlying causes of this dysfunctional behaviour in the family and assist the child and family to adjust to their situation. This example, as well as the others cited below, supports our greatest concern with the legislation as it is currently written.

1010

I turn now to page 4. I would like to speak to the concerns. Of greatest concern is paragraph 26(2)1. I probably do not need to read this paragraph. I am sure you have been hearing about it from some of the other groups as well. We appreciate the difficulties here. From our perspective, we want to emphasize, however, that in health care settings an important aspect of the role of the social worker is to address the mental, emotional and social health of the patient and family. Communicating a diagnostic formulation or conclusion is essential to providing social work services. While social workers are not qualified to diagnose physical disease—drug and alcohol addictions may require further sorting out—they are routinely called on to assess and diagnose disorders and dysfunctions.

Currently, there is no distinction within the act between various social, emotional, behavioural and physical orders and so forth. We feel this leaves the act open to being interpreted too broadly. We feel key terms require definition. Because of the legal jeopardy this clause places on social workers, we therefore recommend that (a) diagnosis remain as a controlled act but key terms such as “communicated,” “conclusion,” “diseases,” “disorders,” “dysfunction” and so forth be clearly defined and placed in a context that would remove the risk of prosecution for social workers in carrying out their normal practice or that (b) diagnosis be removed as a controlled act if key terms cannot be adequately defined, so as to remove the risk of placing professions such as social work at risk.

A second area of concern has to do with the harm clause and our concern that it may be reintroduced. While we respect that there is a potential value in a harm clause which might catch any situations not accounted for under section 26 regarding controlled acts, we are not optimistic that a workable rewording can be found. Our recommendation therefore is that since it appears it would not achieve its purpose of protecting the public and would have a detrimental effect on social work practice, we feel the harm clause should remain out of the legislation.

These are our two main concerns about the legislation. Our last concern that we wanted to identify here has to do with the use of the title “doctor,” which we believe is

inconsistent and unfair as it is currently set forth. In our society, we place value on continuous learning and development. This is recognized in a number of ways, significantly through the use of the title “doctor” upon achieving the highest degree in one’s profession. As written, the act is at least unfair and perhaps discriminatory to all professions and disciplines where the highest degree is a PhD.

This section of the act also seems inconsistent with the desire to recognize the expertise of a broad range of health care providers. While we acknowledge that there are many types of doctors within the health care system, we believe the onus should be placed on the practitioner to identify clearly the professional discipline within which one practises and not to misrepresent oneself. Our recommendation is that no restriction should be placed on the use of the title “doctor.” Practitioners should inform consumers about their professional discipline and must not in any way misrepresent themselves. Penalties should be enacted regarding this latter scenario.

Finally, regarding the complaints procedure, we are aware, from our clinical practice with patients and families, that some members of the public may need assistance in bringing a complaint about professional practice to a college. The complaints procedure is inherently adversarial. Some availability of support and advocacy for those who need it would be beneficial. We are recommending that human and financial resources be made available to provide assistance to those who may require help in lodging a complaint to a college.

In conclusion, while we support most aspects of this legislation, we are concerned about the areas we have identified this morning. It is our strong belief that the public will not be served if its range of choice is curtailed by making social work practice all but illegal under the act. Legislation regarding social work practice in Ontario is needed. Our recommendation is that the standing committee on social development recommend to the Legislature that a social work act be enacted for the self-regulation of the social work profession in Ontario and that such legislation be made compatible with the Regulated Health Professions Act.

What I neglected to say—and I apologize to my colleagues—is that I was making a presentation in my capacity as chair of the association, but we are all here to respond to questions and engage in discussion.

Ms Haec: Thank you very much for your very articulate presentation. It does, as you are probably well aware, echo the concerns of other social work groups we have had before us. I am going to ask a question that has been posed before us—not to social work groups, to other groups—which relates to the fact that as part of your practice, normally the patient has been seen first by a medical doctor, especially in a hospital setting. The patient is not going to come to you directly, am I correct?

Ms Adams: Not necessarily. There will be situations, possibly in an emergency department, for example, where it may be the social worker who sees the patient first; or even situations where the patient may not be the identified patient in the hospital, but the spouse of the patient; or, as

Ted described earlier, it may be a child who is actually the patient, but maybe the parents who are seen as well.

Ms Haeck: In the process of coming to grips with the diagnosis clause and with the communication aspect of it, the initial medical diagnosis, the cause of the particular disease—a broken leg or something else—has been dealt with. But then come the recognition that there may be other family problems that obviously contribute to this person's total problem, which may not be the broken leg. There may be some reason why this person is ill—which is where you come into play. That is usually done more on a referral basis. Right? Wrong?

Mr McNeill: Often it is done on a referral. It depends on the setting. Some hospitals require that an order be in the chart for social work involvement. Others do not. A case may be done by the social worker on the particular team that he or she is assigned to.

Ms Haeck: I am not sure I feel that it is clarified for myself.

Mrs McLeod: I have a dealing with your concern with the diagnosis clause which, as has been said, we hear quite regularly on the committee. There was a clause recommended by the Schwartz task force, which you may be aware of, that was an assessment clause that would have applied to both regulated and unregulated professions, and would have allowed for the assessment and communication of findings. That clause was not contained in the legislation, because I think that legally the diagnosis clause was seen to override it.

You have suggested the diagnosis clause be defined more completely, or dropped altogether. One recommendation the committee has heard is that the diagnosis clause read simply "diagnosis," and the assessment clause be reintroduced—not as a controlled act, but that the controlled act of diagnosis not be defined and that the courts could in fact define that. I am not sure if that is something that your profession has looked at as a possible route, and what your comments would be on that.

Mr McNeill: I think we would still need to have clarification of the definition of diagnosis. In our language, in the tradition of our practice, we would talk about social work diagnoses. We see that as a process we engage in, where we are identifying contributing factors to whatever the mental health concern or social concern may be at that time. Based on that we were deciding what kind of intervention would be appropriate and talking about that with the patient.

We respect that this is a very difficult situation and do not have a ready answer to it. The term "diagnosis" is one that has been used so broadly across the board. I do not know whether you are suggesting that maybe you restrict it to physical disease. Even in that case, it could present other difficulties. The split between mind and body and what is physical and what is emotional is not clear-cut. I mean, it is not just black and white. That is where some of the difficulties come in.

Mr Owens: I think you hit the nail on the head with respect to trying to draw the line between mind and body. One of the other ideas that has been put forth to the committee is that we either remove totally the word "dysfunction,"

or exempt groups like social workers through regulation, as "dysfunction" seems to be a term that is germane to your profession. Do you have any comments about that?

Ms Abosh: The terminology is confusing. "Dysfunction" and "disorder" are terms that we do use. I represent some of the workers in mental health, and it is particularly difficult to sort out if depression is a biological disease or whether it is an emotional disease, and whether it is a dysfunction or a disorder or a diagnosis. It is tough, and this is our concern. We do this readily. To answer one of the questions that somebody posed before, frequently social workers are the first people to see a patient, particularly in a community mental health setting.

1020

Mr J. Wilson: Just a very quick question on the complaints procedure. You recommend financial assistance for complainants. It is my understanding, as I read the bill, that really just a letter to the registrar is required to begin the complaints procedure. At what point do you figure complainants would need financial assistance?

Mr McNeill: It can be a complicated process once they get into it. If there was some kind of resource available which a person could access if he needed it—and that person might have to provide some kind of assessment as to the extent of the support required and how much it would phase throughout that process. From our work, we know that even what might seem a simple referral to a welfare office for community resources is not always straightforward because of the other complicating factors that the patient may present. It is based on some of those kinds of experiences that we feel that some groups in society—maybe those that most need support—may not have it.

The Chair: Thank you very much for your presentation. We appreciate your coming before the standing committee this morning. I hope you realize, and I say to everyone here this morning, if there is additional information that you think would be helpful to the committee during our deliberations, please communicate with us in writing via our clerk.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

The Chair: I would like to call the College of Physicians and Surgeons of Ontario.

Dr Morrison: Thank you, Madam Chair and committee members. I am George Morrison, president of the College of Physicians and Surgeons of Ontario. I have with me Michael Dixon, the registrar of the college; Jenny Coco, a public member of the council and a member of the executive committee, and Rachel Edney, the vice-president.

The College of Physicians and Surgeons of Ontario believes the Regulated Health Professions Act will usher in an era of vastly increased co-operation among health professions. We are committed to making this new system work and we will extend our help to any new profession that wishes to work with us in developing its own system of regulation. In short, we believe all of the regulated professions will be able to forge an effective partnership under this legislation which will benefit the public.

Today we would like to focus our presentation on substantive issues of policy and procedure raised by this legislation. For reference, we have circulated briefing papers and appendices to you. In order to leave time for questions, I will be only highlighting, rather than reading, this whole submission.

In protecting the public interest, our most important criticism of the legislation is the fact that it deregulates much of our health care system. As you know from the airline industry in the United States, deregulation is not always conducive to public protection. Many more professions come under the umbrella of regulation, but the umbrella will not offer much protection. That worries us, because people do not and cannot make health care choices in the same way they make other choices as consumers. When we are worried about our health, or that of a loved one, we do not operate as rationally as we do when we buy a car. The reason for regulation in health care is that we want the range of choices available to be safe and potentially effective.

That will not be the case under the proposed legislation. Reducing the definition of medicine and many other professions to a few specific acts will give untrained, unqualified people a roadmap to follow in treating patients without fear of reprisal. The harm provision was included in the initial legislation to deal with that problem.

The need for a harm provision is supported by an opinion from the Attorney General's office. That opinion is quoted in the background section of briefing note 1 that we have given you. In part it states that section 27.04, which is the harm clause, "is a vital component of the licensed acts scheme." Without that provision to plug the gaps in the controlled acts there will be no way to prevent scenarios such as herbalists wrapping babies in cabbage leaves and prescribing starvation diets, because the herbalist will be able to claim that no controlled act was transgressed.

We realize that one of the key goals of this legislation is greater choice and we support that goal. But we do not believe that any public interest group or member of the public would advocate that the health care choices freely available should include unqualified, untrained people.

We have developed a revised harm provision for your consideration, which you will find in briefing note 1. This revised wording tries to address the concerns of unregulated practitioners by excluding emotional, social and spiritual counselling.

A related issue is the need for public education. Briefing note 2 outlines our suggestions in that area: a public health care data bank, provisions to prevent people from displaying fraudulent degrees, and a truth-in-advertising requirement for all those offering health care. In addition, we believe people have a right to know whether or not a practitioner is a member of a regulated profession before they accept advice from that person about their health. Briefing note 2 provides legislative wording for a disclosure provision.

We applaud the commitment to quality management in health care that is included in this legislation. This will focus regulatory efforts where they should be—on continuous improvement of the professions. However, we will always be faced with some professionals who pose serious risks to the public.

Our college has no effective way to assess a doctor we believe may be incompetent, unless that doctor has committed a serious enough error to be disciplined. Our only other option is to conduct an investigation under section 64 of the Health Disciplines Act, but this only allows us to review records and charts—and doctors may not reveal their incompetence in their records. Our concerns are spelled out in the first few paragraphs of briefing note 3.

What is needed is a new system whereby a practitioner who may be incompetent can be required to go through an evaluation of his or her competence. If deficiencies in skills or knowledge are found, that practitioner can also be required to accept a period of retraining and evaluation. In briefing note 3, we expand on this issue and in appendix 2 we propose legislative wording for a continuing competence system. This is fairly complex and we can see that it may not be possible to introduce it at this point. It may be an issue that should go to the advisory council envisioned by the legislation, in order that a full and frank discussion could be held about an issue which we think is relevant to the ability of all colleges to protect the public.

In January our college commissioned an independent task force to examine the issue of sexual abuse of patients by doctors. The college received its preliminary report on May 27. The task force will be presenting its final report this fall. We are not in a position to recommend legislative changes to you today as our council has not seen the final report, nor had a chance to discuss the final recommendations. As you know, the task force members will make the next presentation to the committee regarding their recommendations, the feedback they have received and the legislative implications in their suggestions for reform.

1030

Maintaining self-regulation is an important professional concern. The announcement in April that public membership on college councils would be increased to just under half comes at a time when our college is doing more to reach out and involve the public in self-government than it ever has before. We have opened our council meetings and discipline hearings to the public. We have reviewed the complaints process with the direct involvement of public interest groups. We have established an advisory committee on multicultural issues. We have been pioneers in the area of peer review and have now established a program to assess a doctor's competence and identify areas of deficiency. We took the unprecedented action of establishing an independent task force to gain insight into how we could improve our efforts in the area of sexual abuse by physicians, and we have already created a committee on quality management at the college.

Our polling of the profession clearly indicates that doctors feel that the principle of self-regulation will be eroded with a council made up of almost half public members. Alan Schwartz felt very strongly about this. We have provided one quotation from the Health Professions Legislation Review. Elsewhere in the review, he also stated:

"The majority of health professionals and their organizations must be relatively satisfied with the system. They should not believe that their legitimate interests have been ignored. The system should not discourage professionals

from co-operating with their colleges, because regulation based on coercion is in the long run likely to be ineffective and expensive."

If doctors no longer feel that they as a group are self-regulating, if they feel the government is accountable for medical regulation, then we believe they will also be far less willing to get involved in helping us protect the public through the college's programs.

There is no question that we are in favour of increasing public representation on our council, and we support a ratio of 60% physicians and 40% public members, but we do not believe that a council made up of almost equal numbers of doctors and lay people can truly claim to be a self-governing body.

We have already heard the view expressed by the Council of Ontario Faculties of Medicine that reducing the number of academic appointees on our council would not serve the public or profession well. We would lose the academic input on a number of committees, and I think the most important area is the task force on sexual abuse and the recommendations arising from that. We urge the committee to retain the current level of representation, one appointee from each faculty of medicine in Ontario.

We would also like to express our concern with the amendment which would sunset appointments to council after two three-year terms. We believe two four-year terms or three three-year terms would be more reasonable.

Madam Chair, let me reiterate that the college supports the thrust of this new legislation and believes that bringing a greater number of professions under the umbrella of self-regulation will give a greater sense of community to the providers of health care in Ontario and a greater level of involvement in health care for the public. We believe that the suggestions we have made today will address significant problems with the draft legislation that you have before you.

The Chair: Thank you for your presentation, an excellent presentation, I think all members will agree.

Mr Beer: Thank you very much for your presentation and for all of the other background material which we will be able to look at. I think one of the important questions we would want to raise with you concerns the functioning of the council, and particularly the participation of professionals and the public. You have suggested in your brief that perhaps the ratio of physicians and public members would be 60 to 40, and I wonder if I might ask the public member representative on your council to elaborate a bit on how you have come to see that balance in terms of the council being a truly self-regulating, self-governing body, and if you believe that there is a need to make further changes. Is there something between—I guess a third was the original proposal—between that and 48% or 49%, the 40% sounds like it has come down the middle. From the public's perspective, could you set out how you feel that would continue to ensure public input and yet be a better self-regulating body?

Ms Coco: I think we have to remember that there has to be a partnership develop between the physician members of council and the public members of council. To date

we have not had the problem of voicing our own concerns to the council members, both medical and non-medical, and we have always had an effective voice on council; but to work effectively, I think we have to have the partnership. If ownership is important to the medical profession, then I think the compromise of partnership would make it more effective for the public representatives.

Mr Beer: What would we be talking about then, just for the record, in terms of the numbers who would be on council, and how many of those would be public members?

Ms Coco: Presently we are proposing 40%, which I believe is in appendix 4. With that ratio, we are proposing the number of elected doctors be 16, the number of academic appointees 5 and the number of public 12.

Mr Beer: You note in the specific proposal that the legislation would perhaps use permissive wording, so that, "the minister may appoint up to 15 lay members," and I take it that would be to provide flexibility from your point of view.

Ms Coco: Yes.

Mr Owens: Dr Morrison, regarding your presentation on the quality of medical care, you make a statement about wanting to protect the public against "cabbage leaf wrappers," and then in your comments you also make a comment that you have very limited means of assessing your own physicians. I am wondering if you can tell me, within the last 10 years, how many members of your own profession have actually faced disciplinary proceedings for breach of practice, versus the number of the cabbage leaf wrappers of the non-traditional practitioners of medicine who have been prosecuted or in some way disciplined?

Dr Morrison: I am going to ask the registrar for that.

Dr Dixon: In terms of members of the profession who have gone to discipline on various charges, we are averaging approximately 80 hearings a year. It has increased in the last few years and currently we have quite a substantial backlog that we are working on. In terms of prosecution for what is generically known as the illegal practice of medicine, be they unrecognized, untrained practitioners or in some rare cases people who are registered in other professions, this has averaged one or two cases a year over the last decade. That information had been summarized and had been provided to Mr Schwartz during the course of his review.

1040

Mr J. Wilson: Thank you very much for your interesting presentation. Just to pick up on what Mr Beer was alluding to concerning the number of lay appointees to council, I can understand your concerns that increasing the number of lay appointees to just under 50% may erode the principle of self-regulation. Do you not think that in the long run, with people entering the medical schools knowing that this is the case in the profession, it may lead to greater public confidence in the profession?

I just think that in the bad press surrounding the sexual task force, and certainly among constituents, you had people questioning the medical profession. I think people generally, probably our constituents, the average person on the street like the fact that they will have more say in the regulation and the running of the college, for instance. Do

you want to comment on that? Certainly the thought is out there that in the long run this may be good for society.

Dr Morrison: I guess I come from a sense of responsibility as a professional, both to my patient and to my profession. We do have a responsibility to insist that all of us measure up to an acceptable standard of care and concern. I think that is what self-discipline is about. I must admit that there used to be an argument that only doctors knew how to deal with it, but there is an increasing sophistication in society that the public does have a role to play in this, and I strongly embrace that concept as well.

I still think that we as a profession have performed well in this society. I think the leadership given by my predecessors on the executive in the last few years has been particularly proactive. I think the benefits of a self-disciplining profession, not just medicine but all the others, should also be looked at. I think there are benefits to the government in terms of arm's length. I think there are benefits to the public if it has confidence in the fact that the professions are self-disciplining.

You may say that confidence has been shaken a bit. I think you could argue that we ourselves were the ones who identified the need to explore the sexual abuse problem and it reflects, to our credit, that we did face a very difficult issue. On balance, I think a sense of self-pride as a professional is important. The public should be happy that we have professionals like that. I think that all three parties—government, public and profession—benefit from the concept of self-regulation as it exists.

Mr J. Wilson: Thank you, I appreciate your comments on that. You mention in the brief that the minister has increased powers, and I can tell you that I think the committee, as we are relatively new to this sort of thing, to be truthful about it, and we are lay people, elected representatives, may not have a sense of what the powers of the minister were and are. Do you want to comment on that? I think your contention is that there is greater public protection because one of the factors is that the minister has increased powers in this new act?

Dr Morrison: I wonder, Michael, if you might give a cleaner answer to that.

Dr Dixon: Well, very briefly; I can see the Chair staring me in the eye.

Mr J. Wilson: She does that all day.

Dr Dixon: Under the existing act, the Minister of Health has the authority to request the councils to do various things. In particular, the minister has the responsibility to request the council to make a regulation. If the council refuses to make the regulation within a period of 60 days, the minister has the authority to make the regulation herself. Under the new legislation, that time period of 60 days is removed and the minister has the authority to require the council to make a regulation and in fact do anything else that the minister, in his or her discretion, feels is indicated in the public interest.

So in fact in the new proposal there is much greater direct authority. Under the current legislation, I do not think any council was under the illusion that it was an autonomous body and free to take on any activity or deny

any activity that it felt appropriate. The councils now simply have more direct accountability, and also the minister has more direct authority over the councils.

Mr Johnson: With regard to the per diems paid to the members on the council, are they uniform? If they are not, I was wondering if you could give me some range as to what the per diems are.

Dr Morrison: The public members are paid by the government and the council members, who are professionals, are paid separately. That varies within each of the colleges. I know that the dentists, because their office expenses are considerably higher than ours, pay their members more to serve than we are paid. Our per diem is in the area of \$600 and the public members are I think in the area of \$125.

I think it is a very difficult issue as to how government should pay for these services. Many of the people who are participating are there I am sure because of a sense of public responsibility. They feel that it is an important contribution they are personally making. There are advantages of being able to come to Toronto. I do not see many, but some people like to do that.

Mr Johnson: Nor do I.

The Chair: We appreciate your coming before the committee this morning and we appreciate your excellent presentation. I would like to thank you, and we know as well that if there is additional information that you think would be helpful to committee members, you will communicate further with us in writing. Thank you for coming this morning.

TASK FORCE ON SEXUAL ABUSE OF PATIENTS

The Chair: I call now the Task Force on Sexual Abuse of Patients. We have all received a copy of your presentation.

Ms McPhedran: Before we begin I just draw to your attention that you have the presentation we are making, plus the list of recommendations from the preliminary report which may be helpful later. If you lose this part and do not include it with the other part, you are not going to know where it comes from because it does not have a heading.

The Chair: For your information as well as everyone else, all of the documents received by the clerk on behalf of the committee become part of the public record.

Ms McPhedran: Let me begin by introducing myself and my colleagues. My name is Marilou McPhedran. I am the chairperson of the Task Force on Sexual Abuse of Patients. Someone you have met already, Dr Rachel Edney, is also on the task force, as well as on the executive of the College of Physicians and Surgeons of Ontario. Pat Marshall is the on-leave executive director of the Metro Action Committee on Public Violence Against Women and Children, and now the co-chair of the new National Commission on Violence Against Women. Dr Harvey Armstrong is very dedicated to being, as he says, the token male on the task force and, as we constantly remind him, he has time and time again demonstrated skills and expertise and has shown that this is an issue for men and women to deal with and to be very concerned with.

Because of the shortness of time, we do not propose to read this word for word. We want to say a few words at the beginning about philosophy, and I am going to be asking my colleagues to say a few words on that. Then I can take you very quickly through the main points about actual amendments to the code that we want you to consider. We are hoping we can do this in half of our time, to leave half for questions. If you could guide us, that also would be very helpful.

I am going to ask Pat to put in context the recommendations we are making, making them consistent with a philosophy and a commitment to zero tolerance. I will just bring to your attention, before Pat speaks, the last page of our presentation, which is a July 11 letter from the Premier. We were absolutely delighted when he wrote to us to say, "Our government is also committed to zero tolerance of sexual abuse."

Ms Marshall: In December 1985, the board of directors of Metrac, the Metro Action Committee on Public Violence Against Women and Children, agreed reluctantly to my suggestion that we participate in the health professions legislation process and discussion because sexual abuse by health professionals was not an issue that seemed to be addressed very effectively according to the public hearings we had had and a task force from 1982 and in our work.

1050

The terminology of the old Health Disciplines Act that talked about sexual impropriety, even that euphemistic term, we recognized as problematic to cover rape and sexual assault. We were hearing on a regular basis instances of sexual abuse by health professionals that did not seem to be dealt with very effectively by either the criminal justice system or by self-regulating professions.

As a result of that, we began a process that has ended up with both Marilou McPhedran, from the board of directors of the Metro Action Committee on Public Violence Against Women and Children, and myself working with the college in its leadership role in pointing the direction of self-regulation and in dealing with sexual abuse involving a breach of trust.

Zero tolerance of sexual abuse is something that almost everyone we have talked to subscribes to, but what we have tried to do is articulate what it means in terms of policies, practices and procedures. No one will admit or support sexual abuse in the first instance, but what in fact was happening was that because there was not a very clear recognition of how pervasive it is, what the impact is, what it really involves, there were no processes and policies in place that were responding to it.

That is one of the main things we have tried to do, that is, try to name the experience, name the response in the clearest, most unequivocal communication possible. As you will know, the council of the College of Physicians and Surgeons has adopted already unanimously this philosophical foundation.

It is the litmus test. It is the basis upon which all the other recommendations come, and we encourage you to think about zero tolerance of sexual abuse in your own discussions of these regulations, and also to keep in mind,

although the charter does not formally apply, the spirit of the charter and that right to equal benefit and protection of the law that must extend to sexual abuse survivors as well as to others in our society, including the professionals.

Ms McPhedran: We would also like you to consider one of the most discussed proposals that we have made: the current definition of sexual impropriety as a form of professional misconduct, that is in the Health Disciplines Act. We would like you in your deliberations to consider our proposal about the change that should be made, which is to create two offences: to clearly define sexual abuse as an offence and also to define sexual impropriety separate and apart from being just one of a list of over 30 examples of misconduct and instead to place it on its own, along with sexual abuse. You will find this at page 7 of our presentation where we outline our proposal.

The final report of the task force will be available later this fall. It is likely that we will be making some modifications to this proposal, but we will not be making any change to our basic proposal here, which is that these two offences should be placed within the RHPA and the HDA, if that is necessary.

In order to place in context for you the importance of this proposal, I am going to ask Dr Armstrong very briefly to give you some information about his own practice with sexual abuse survivors and why this proposal is appropriate.

Dr Armstrong: When patients go to physicians and they experience demeaning language, sexist behaviour, humiliating draping, destructive comments about their underwear or clothes, they really get frightened and turned off health care. Sometimes, in the time we have been travelling, we have run into people who have had to travel hundreds of miles to get health care in small communities because this is what routinely happens in their practice. I think that is due partly to ignorance, partly to just not being sensitive. That process, those kinds of behaviour, need to be stopped, and we are very clear that is not done quite as maliciously and destructively as sexual abuse.

Sexual abuse is much more serious; it is behaviour really that involves exploitation of patients. It is not clumsiness. It is not stupidity. It is not lack of knowledge. It is not lack of sensitivity. It is exploitation of people for the physician's purposes, and that is much more serious.

The kind of behaviour we have encountered in the process of going through the hearings, and in my practice, includes people having sexual intercourse with physicians in their hospital beds, having years and years of prolonged and humiliating sexual abuse, and patients going back and back, partly because there may be no other resource available to them for medical care and sometimes because they just hope this abuse is going to turn into love.

You must remember too that many people who are abused by physicians are victims of childhood sexual abuse and are very easy to victimize. These exploited people generally are very often victimized. If you look in the histories of people who are abused by health care providers, in the research that exists, most of them but not all of them, a significant majority, have been abused as children. Their response to the physician's sexual advances is partly

due to the childhood exploitation and partly due to the fact the physician has trust, power and knowledge and is respected excessively.

Ms McPhedran: Would you like to proceed to questions or would you like me to go through and just highlight the code sections we are addressing?

The Chair: The time is yours and we have time for whichever you would prefer. I think the committee members would very much like to ask questions.

Ms McPhedran: I will very quickly summarize.

One of the recurring themes in this presentation is the need for greater participation of the patient in complaints hearings, in the disciplinary process. There are a number of proposals for amendments to the RHPA code which address that.

In addition to that, we say it is very important that you categorically create the right of access to medical files for all patients, not just patients who have their files in psychiatric facilities.

We are very concerned that the current time period proposed, six months before the complaints committee receives the complaint and makes a decision, is longer than the college currently takes. We feel it is perfectly adequate to go to 120 days to reflect the existing reality. Those 60 days can make a very big difference for both the patient and the doctor, who are extremely anxious. The faster the system can move, the better.

We look at section 30 of the code and ask you to pay particular attention to vulnerable witnesses. As a very high-ranking lawyer in the Ministry of the Attorney General said to us on Friday when we met, a vulnerable witness is a vulnerable witness, whether it is a child or whether it is someone who is suffering from post-traumatic disorder as a result of assault.

On the matter of public members on the discipline committee, we are looking at section 38 of your code and we feel you should very clearly require that the public member be there throughout the hearing process and not simply for a hearing to commence, so that you may be sure the participation of the public member enhances the entire proceeding and is not just pro forma.

Looking at prejudice towards the patient complainant, we are asking that section 39 be reviewed in light of the research now available about post-traumatic stress disorder.

Section 41 needs to be reviewed in light of the emphasis only on disclosure to the defence, thereby giving no opportunity in advance of the hearing to the college or to the patient to prepare for the defence. This is an administrative tribunal. It follows civil proceedings and it is absolutely not necessary to continue to import this notion, which is essentially a criminal notion, that the defence does not need to be disclosed in advance of the hearing. It results in inefficiencies and it results in injustice.

Section 63 of the proposed code carries through what is in the Health Disciplines Act and talks about the fitness to practice committee having the right to specify "any person" as a party. We are saying the same power that you have for the fitness to practice committee should be extended to both the complaints committee and the discipline committee,

thereby providing the most effective way in law to increase the participation of patients in the process.

At page 4, we talk about the survivors' compensation fund. This is a brand-new concept. One of the rather amazing things we have discovered is that although lawyers established a compensation fund for victims of lawyers who had bilked their clients and had been found guilty of so doing almost 40 years ago, no such thing has ever been done by the doctors in this province to compensate their victims in any way. We are saying that it is high time the medical profession assumed its collective responsibility and established such a fund, and we lay out our proposal there.

1100

We also point out that section 50 of the code should be amended to include a much greater fine than is allowed for incompetence, as well as for other offenses which already do have fines attached to them, and this money should go to the compensation fund. It should be there to allow for genuine attempts to compensate in some way for the enormous damage that has been done.

On section 69, we ask that sexual abuse be included as a ground of incompetence or incapacity. Once again, it is just to integrate sexual abuse throughout the code to make it possible for all the various permutations and combinations of facts to be covered, using the code. On the limitation period, we refer you to the March 1991 report of the Attorney General that recognizes that "In some circumstances, the sexual assault will render the victim incapable of considering legal proceedings until many years after the event." Change the code of RHPA to reflect this reality. Do not keep your one-year limitation period, which only acts to the benefit of the abusing doctor.

Increased public representation: we have made some mention of that. Disclosure of all parties: we have made mention of that. We have also talked about delay as a form of injustice. We invite any questions you may have now with the short time that is available to us.

Ms Haec: This is an extremely timely presentation and I would like to refer you to the College of Physicians and Surgeons of Ontario presentation and your comments with regard to public representation on the college of physicians and surgeons. Do you view the near-50% representation on the college of physicians and surgeons in the same light as the college does?

Ms McPhedran: I do not think we took a clear position on that. To be honest with you, I was not in the room when the presentation was made. It was standing room only when that part of the presentation was made. Certainly our report has reflected and will continue to reflect a very clear commitment and a support on the part of the task force to increase public representation in this process. One of our recommendations, for example, is that there should be clearer direction in the code and RHPA to have more public members on the committees. Logically speaking, if you are going to do that, then you need to have more public members than currently sit on the body.

Ms McLeod: I would not like to ask a specific question without first stating a complete acceptance of the philosophy that Pat Marshall outlined in the introductory remarks

respect for the work the committee has done and appreciation of the college of physicians and surgeons for having set up the independent task force. I think it is appropriate to put any specific questions into that context. I did want to ask a question about the definition of sexual abuse, which I am sure has been a cause for considerable discussion among your committee members.

It comes back to Pat's comments about the importance for absolutely clear communication and understanding. I am sure the question of whether or not it is difficult for the patient to know what is appropriate and necessary as part of a standard medical examination, is an issue of clear communication, particularly as it should be quite clear in terms of sexual intercourse and kissing, but less clear as you get to the definition of touching breasts and genitals. Could you say a little bit more about this whole question of the clarity of communication in that definition and whether, for example, the recommendations about brochures, indications of what warnings patients should be looking for will adequately address this question of the confusion that may exist in the patient's mind?

Ms Marshall: We all could respond to that. In our hearings we heard women who were absolutely clear—and I am quite convinced that both women and doctors can be absolutely clear—about what is appropriate touch and what is not. The majority of doctors, when we talked to them, have no question at all about what is appropriate and they are confident that they can communicate that to the patients. As we talk to women, they are pretty clear and I have not heard confusion about inappropriate touch. There are things that have felt inappropriate which they have questioned and then questioned the bad feelings they have had afterwards. I think there is often some need to validate that those feelings are absolutely appropriate because it was inappropriate touch. But we found it is not an issue around which there is confusion and the misinterpretation of appropriate medical practice as inappropriate.

Mr J. Wilson: Thank you for the presentation. Your recommendation 24: As you know, my colleague Ernie Eves introduced a private member's bill dealing with sexual abuse. As a caucus, we are very supportive of that. Just as a point of process, perhaps you could clarify it for me. In the new act, are you asking us to include these definitions? I am just wondering about the timing. Your final report comes out in the fall and we are making our deliberations now and going into clause-by-clause in mid-September.

The Chair: After the House returns, which is September 23, likely through the month of October.

Mr J. Wilson: Do you want to comment on that? We may be pre-empting.

Ms McPhedran: I did try to address that a little bit when I said that while we may make some modifications in wording, we will not be modifying the concept of two levels or the use of the term "sexual impropriety," the use of the term "sexual abuse" and the indicators that we have mentioned. What we are saying to you is that there is not going to be a significant change in the final report from the preliminary report in this area, and we invite you to further your own deliberations. We hope we have pointed you in

the direction to go. It is certainly open to you as a committee to seek further advice and to develop the definitions as you see fit.

Ms Marshall: In terms of penalty, if I may just address that, because we have not mentioned that at all, it is important and we urge you to consider the literature on rehabilitation. It is not, at this point, possible to identify prospectively rather than retrospectively a doctor for whom any rehabilitation program is successful. That we are quite clear about in our review. It is impossible to tell, among those who have gone through the program prospectively. Given the tremendous power, privilege and position of trust that is given, we have very grave concerns, obviously, about reinvesting that when we cannot tell ahead of time, because of the very early stage of development of rehabilitation programs, which doctors rehabilitation is going to be successful for.

Mr J. Wilson: That is a very good point.

The Chair: With consent, maybe I would just like to put one question on the record. Perhaps through written brief and submission you could inform the committee at a later time. Your work was done under the auspices of the college of physicians and surgeons. There are many other health professionals who, I believe, would want to address this very significant issue as well. How would you propose that under this legislative framework? I am not going to ask you to answer that today, but I think that is a question all committee members would like you to consider and submit in writing. There will be an opportunity with the final presentation of your brief this fall to give us your advice on that.

Ms McPhedran: Madam Chair, recommendation 20 of the preliminary report is that, although the task force was only commissioned to look at the medical profession, we see absolutely no reason why any of the recommendations that you have before you today from the task force should not apply equally to the other health professions governed by the RHPA. That is our recommendation to you. I think that gets wrapped up as a package. We really think this committee has an exciting opportunity to look at a code of conduct in the procedures that relate to sexual abuse victims in all the health professions. There may well be areas where some of the procedures need to be fine-tuned to reflect what we now know to be the actuality of rape trauma syndrome, post-traumatic stress disorders and what that means in changing our procedures and reflecting the reality of patients who have been sexually abused in any health profession.

The Chair: Did you have any representation made to your task force from any of the other professions or colleges?

Ms McPhedran: We have received a number of written briefs from other professions that are to be regulated under this bill, yes.

1110

Mr Owens: Madam Chair, with further permission of the committee I would like to ask whether we could also have some thoughts with respect to the use of an advocate by complainants, especially when you refer to the vulnerable

patient, recognizing that we are trying to make the system as accessible as possible but due to the nature of the issue we may lose some folks and we clearly do not want to do that. How would you see the role of an advocate assisting in getting the complaints filed and "prosecuted"?

Dr Edney: I think we would be very comfortable with that. We have recommended that the complainant should have support. I do not know whether that is quite the concept you have of an advocate, but the complainant should have support throughout this process and an advocate should be with the complainant at the college. We have an advocate, actually; we have somebody at the college now who is a college employee and is there to help patients. Somebody from outside to support the complainant, paid for by the college would be something we would support.

The Chair: Thank you very much for an excellent and very significant presentation before the committee today. As I have mentioned to others, we hope you will communicate with us in writing if there is additional information you think would be helpful to committee members as we continue our deliberations.

The committee recessed at 1112.

1118

COLLEGE OF OPTOMETRISTS OF ONTARIO

The Chair: I call the College of Optometrists of Ontario.

Dr Garnett: Thank you, Madam Chairman. With me today are: Irving Baker, registrar of the college; Bud Cockerton, a public member of council and also a member of our discipline committee; Ross Morrison whom I will introduce more fully later. My name is Brian Garnett. I practise in London and am president of the college. As you know, the college is the regulatory body of the profession of optometry. Its authority to govern its members is given by the Health Disciplines Act. The profession of optometry has been governed by provincial statute in Ontario since 1919. As a result, the college has gained considerable experience in the regulation of the profession and in the administration of its statutes.

We have carefully studied Bill 60 and Bill 43. Our comments today, we hope, will reflect the recognition of our responsibility; that is, to act in order that the public interest may be served and protected. Our written submission is in two parts. Each contains recommendations to the committee. Part one deals with our concerns with the scope of practice definition and the authorized acts in Bill 60. These elements, as you know, serve to define the profession of optometry. Part two deals with legal and procedural matters. In Bill 43 there are a number of improvements we think can be made to improve the administration and the effectiveness of the statute. Our oral presentation today will deal only with part 1, the definition of the practice.

An accurate, statutory definition of a profession is absolutely central to self-government of that profession. Bill 60, as drafted, does not accurately define the profession of optometry. Omissions in the scope of practice statement and the authorized acts lead to that problem. In preparation for this presentation, we obtained the written submissions

to this committee from other optometric groups. You are aware no doubt that the overwhelming concern was with a reduction in the scope of practice of optometry that would occur. The college is in complete accord with the opinions expressed by these other groups. Optometrists would not be able to provide the services they have in the past.

I would now like to introduce Ross Morrison. Mr Morrison is a lawyer in the firm of Shibley, Righton. He acts for the College of Optometrists of Ontario before the discipline committee. He acts in the same capacity for other colleges. We have asked him to share with you his opinion on the implications of the proposed legislation in these critical areas.

Mr Morrison: In my capacity as counsel to the college, with particular emphasis on the prosecution of charges of professional misconduct before the discipline committee of this and other colleges, I was asked to provide my opinion with respect to the interpretation of certain provisions of the Regulated Health Professions Act, Bill 43, and its companion legislation, the Optometry Act, Bill 60. More specifically, I was asked to consider the controlled acts provision of the Regulated Health Professions Act and the scope of practice and authorized acts provisions of the Optometry Act.

At the outset, it must be noted that a controlled act, under the Regulated Health Professions Act, includes communicating to an individual a conclusion, identifying a disease, disorder or dysfunction as the cause of symptoms of the individual. On the other hand, both the scope of practice of optometry and the authorized acts which an optometrist may perform, as defined in the Optometry Act, include diagnosis, treatment and prevention of vision and oculomotor dysfunctions and the communication of a conclusion identifying a vision or oculomotor dysfunction of the eye, but they do not include diagnosis, treatment and prevention of diseases or disorders of the eye or the communication of a conclusion identifying a disease or disorder of the eye as the cause of a person's symptoms.

I have expressed to the college my opinion on the fact that the Optometry Act is silent in identifying diseases or disorders of the eye as within the scope of practice of an optometrist and within the authorized acts which an optometrist may perform. My opinion is that such silence will likely adversely impact the ability of the college to administer the statute to maintain the standards of practice of the profession and ultimately to protect the public interest.

Identification of diseases or disorders of the eye or vision system and the communication of such conclusions by an optometrist to his patient are integral parts of the practice of optometry. I have several reasons for expressing the opinion which I have so expressed to the college.

A practitioner is obliged to provide services to a patient in accordance with accepted professional standards of practice. In the context of insured services for which payment to the practitioner is made by the Ontario health insurance plan—this obligation is codified in section 24 of the Health Insurance Act—the Divisional Court has ruled that the standards to be considered are those of the profession itself, drawn not only from the regulations under the Health Disciplines Act, but also from advisory notices which the college publishes and from expert evidence.

Those advisory notices include the manual respecting the clinical practice of optometry which is now the guide to the clinical practice of optometry that is published by the college. It is distributed by the college to its members and it provides very clear guidelines relating to both diagnostic and treatment services. Those guidelines are not limited only to determining and communicating vision and oculomotor dysfunctions of the eye. There are regulations under the Health Insurance Act, specifically section 47, which define certain services rendered by optometrists and insured services under the Ontario health insurance plan.

Before those regulations were amended in April 1989, the insured services included oculo-visual assessments, V401; oculo-visual reassessment, V402; partial oculo-visual assessment, V403. Since April 1989, those insured services have been redefined and limited to what is referred to as a first oculo-visual assessment, and it is still identified as a V401, and a follow-up oculo-visual assessment, again a V-402. But it is noteworthy that under both the old and the new regulations oculo-visual assessment includes, and I am quoting from the regulation, "the presence of any observed abnormality in the visual system," which in my view necessarily includes not only dysfunctions, but also diseases and disorders of the eye.

In a similar manner, sections 23 and 36 of regulation 450 under the Health Disciplines Act oblige a member to exercise generally accepted standards of practice and procedures in determining the physical, optical, sensory and oculomotor state of the eye and adnexa and in the assessment and care of the patient's vision. The member must, in addition, make and keep clinical records. Those records must detail all examination procedures used, clinical findings obtained, treatment prescribed and provided.

The regulations do not limit the findings of the member with respect to the state of the eye, to vision and oculomotor dysfunctions, but rather they impose upon the member the obligation to diagnose, communicate and record not only dysfunctions, but also diseases and/or disorders which are discovered in the course of determining, as the regulation words it, physical, optical, sensory and oculomotor state of the eye.

The role of an optometrist in the assistive devices program of the Ministry of Health is, in my view, also significant. The ADP, as you know, provides financial assistance to visually impaired residents of this province, among others, for the purpose of obtaining specified low-vision aids. The ADP recognizes optometrists as authorizers of low-vision devices. In that capacity, optometrists must provide not only a primary diagnosis, but also a secondary diagnosis if any, for example, cataracts, cerebral palsy. Arising out of this obligation upon optometrists under the ADP, is in my view a recognition and acceptance that the scope of practice of the optometrist includes diagnosis and treatment not only of dysfunctions, but also diseases and disorders of the eye.

I have advised the college that the application and interpretation of the legislation as proposed, and specifically with reference to these sections which I am addressing, raises concerns with respect to the successful prosecution of members on charges of professional misconduct before the discipline committee of the college. A member who

has been charged with professional misconduct, for example by failing to maintain the standards of practice of the profession, may raise as a defence thereto that the charge involves a disease or disorder and not a dysfunction of the eye and is therefore outside the scope of practice and the authorized acts of the member.

In summary then, it is my view that under the current legislation and regulations as presently in place, the practice of optometry includes the diagnosis and treatment of diseases, disorders and dysfunctions of the eye. The legislation as proposed will limit the scope of practice of optometry to diagnosis, treatment and prevention of vision or oculomotor dysfunctions of the eye and as such is inconsistent with the historical pattern of the practice of optometry in the province of Ontario.

The new legislation, in my opinion, will redefine the scope of practice, and with it, the generally accepted professional standards and practice of the profession and will consequently impair the ability of the college to maintain the standards of practice of the profession and ultimately to protect the public interest.

1130

Dr Garnett: I would now like to address your attention to page 2 of our brief. There you will find our recommendations on the scope of authorized acts. These recommendations would, we feel, properly describe the practice of optometry; retain the status quo, in other words. These recommendations were approved by council one year ago.

You may notice that the scope-of-practice statement looks familiar. It is in appearance almost exactly the one you were given two days ago by Brent MacInnis of the ophthalmology section of the OMA. They agreed that the scope of practice statement in Bill 60 is too restrictive. Their suggested scope statement has one extra word "refractive." That is, optometrists diagnose, prevent and treat refractive diseases and disorders of the eye. Unfortunately, the phrase "refractive diseases" just will not work.

You heard and we agree with the statement made by Alan Burrows in London. He said that considerable progress had been made toward consensus on a scope definition. You are seeing how close we were to consensus. The residual issues were, was any modifier necessary, and if so, what was the right word or phrase? As you see, our recommendation is that no modifier is necessary and here is the reason. There are controls beyond the scope of practice statement in the authorized act to prevent practices which exceed the recognized limits of the profession. These controls are found in the regulations and in the standards of practice. For example, there have been no qualifiers in the Health Disciplines Act in 17 the years of administering that act. There just have not been problems with members exceeding the recognized scope of practice.

I have to tell you something that happened this morning. I did not sleep particularly well. I was out running at 6:30. Running through my mind were disease, diagnosis, dysfunction, refractive.

Interjections.

Dr Garnett: Yes. A light came on, and I hope you are as excited about this as I am.

The Chair: This is really exciting stuff.

Dr Garnett: Well, for us it is. By moving one word, the word "refractive" in the definition that Brent MacInnis gave us, we have a description of the scope of practice of optometry that is perfect. I checked with two legal counsels this morning, and they are entirely satisfied that this does describe the practice of optometry. We appended to your brief a page at the back which gives you that definition. It was just inserted this morning, and we think it does the job perfectly well.

In summary, then, on the scope-of-practice issue, every group that you have heard speaking on Bill 60 agrees on one thing: The scope-of-practice and authorized acts do not accurately describe the practice of optometry; second, we are within one word of solving the problem, and finally, we offer our complete co-operation with this committee and with the ministry to achieve a solution. We have also provided you with a number of amendments to Bill 43 dealing with legal and procedural matters that we think will result in improved legislation.

I thank you for your attention and for the opportunity to appear today; we would be pleased to entertain any questions.

The Chair: It is not often that the committee responds with humour; and it is appreciated.

Mr Cordiano: I want to go back to the legal opinion—obviously, that is where the crux of the matter lies—and ask if you will give me an example of the distinctions between what is in the scope of practice, which is the identification of a dysfunction, versus the disorder and disease, which is not in the scope of practice, as I understood it. Could you give me an example of how that might arise and how you might make that distinction?

Dr Garnett: Depends on what may be considered to be a disease or disorder as opposed to a dysfunction.

Mr Cordiano: Exactly.

Dr Garnett: I wonder if Dr Baker might address that issue.

Mr Cordiano: In general terms, of course, without getting too specific.

Dr Baker: Let me make a comment. I am sure you have heard this from other groups. One of the major problems is in fact to make a distinction between disease, disorder and dysfunction, because all you can really get out of that is opinion. I can tell you what I think the disease is, or disorder or dysfunction, but that may not necessarily be the opinion of someone else. The real problem, at least from a practice point of view and a statutory point of view, is that very often if you take the act technically, you do not know whether you are dealing with a dysfunction or disorder or a disease, because my opinion is that dysfunctions are the result of diseases and disorders. It is a very complicated business, and I cannot give you a direct answer. I can give you a name. A person has blepharitis; that is considered to be a disease. You know, that kind of thing.

Mr Cordiano: Your scope of practice—in your opinion, it is very limiting, obviously.

Dr Baker: That is right.

Mr Cordiano: And then I would turn to legal counsel for the ministry and ask was that the intention of the review with respect to the scope of practice?

Mr Wessenger: I will refer that to counsel, though my complete understanding is that there is no intention to restrict, but just to have the existing scopes of practice continue. But I will ask legal counsel to refer more specifically.

Ms Bohnen: The challenge the review had was to find the right terminology within the framework of its model to capture accurately what optometrists and other practitioners with their statutes, do. It is usually but not always easy to agree on the activities that the professionals perform and the actual specific conditions where they interact with patients. It is much more difficult to capture the right legal terminology or statutory terminology that reflects that accurately.

The review believed that the most accurate way of describing what optometrists do is that they have a very broad assessment capability, and that is reflected in the review's recommendation. However, in terms of diagnosis, their capability is more limited. The profession obviously disagrees with that. I think there is consensus at least between the optometry profession and the ophthalmology profession, that they do, indeed, diagnose some diseases and disorders, but not all of them. You are hearing from the optometrists that other mechanisms such as the self-discipline of the profession are sufficient to confine optometrists to diagnosing that which they are properly qualified to diagnose. The government's view is that the statute should also set out that which they are capable of diagnosing and that it simply is not all diseases, disorders, dysfunctions.

Dr Baker: I think the brief comment is that no member of any discipline is capable of diagnosing everything.

Mr Hope: I can relate to what you are saying about jogging and thinking about this. Some of us have to jog for others who do not jog. I see a number of colleges and other people getting legal counsel. I am wondering about the changes to legislation and being more in the public's eye. Are you worried about turf battles among the colleges or are you worried about the general public's perception about what is going to happen? I am just wondering why so much legal counsel in this whole—

Dr Garnett: The scope of practice definition is so central to everything this college does, and the college's mandate is to serve and protect the public; if we do not have a proper definition, we cannot carry out that mandate. It is as simple as that.

Mr J. Wilson: I was just wondering, can ophthalmologists live with your falling off your horse this morning?

Dr Garnett: I did not meet one on my run, so I cannot reply to that question.

1140

Mr J. Wilson: There is terrible confusion between opticians, optometrists and ophthalmologists, and probably the most confusing part of the whole process is you guys.

Dr Garnett: I can understand your concern. I realize it is confusing, and I can see where it has been a very difficult job for ministry officials. We sympathize, and as I

said, we will do our best to get a result that will operate in the public interest. That has always been important.

Mr J. Wilson: Just quickly, will you be chatting with ophthalmologists—

The Chair: Order. Thank you very much for your presentation this morning. We appreciate you appearing before the committee.

ASSOCIATION OF CHIEF PSYCHOLOGISTS OF ONTARIO SCHOOL BOARDS

The Chair: I would now like to call the Association of Chief Psychologists of Ontario School Boards. I would remind everyone that they can continue to communicate with the committee any additional information that they feel would be helpful at any time through our clerk.

Dr Blackstock: My name is Edward Blackstock, and my colleague is Lynne Beal. We are chief psychologists with school boards in Ontario. I am the president of the association, and Lynne is the secretary. I will start by thanking you for providing us with the opportunity to address the committee today on behalf of all the chief psychologists for all the school boards in Ontario.

As chief psychologists in school boards, we are responsible for the provision of psychological services that are delivered by a very large number of practitioners to children in Ontario schools. Our staff includes both registered psychologists and their associates who work under our supervision. It is our responsibility to ensure that the psychological services delivered by our staff meet the standards of practice for the profession, for the protection of the children and their parents who are our clients.

We support very much the proposed Regulated Health Professions Act. We believe that accountability to the public, protection of the public and efficient and effective service are essential components of standards of practice for psychologists. However, we have some concerns about the RHPA and the proposed Psychology Act and will outline those for you.

Section 15 of the Psychology Act restricts the use of the title "psychologist" to members of the College of Psychology, only when such members are "offering to provide, in Ontario, health care to individuals." Psychologists practising in school boards are currently regulated by the Psychologists Registration Act. The new Psychology Act, as it now stands, would exclude psychologists who work in school boards, and in effect would deregulate them. We believe that this exclusion would not be in the best interest of the public for the following reasons.

Dr Beal: The first one is that the majority of children in Ontario who receive psychological services receive them at school through psychological services departments of school boards. Our clients range in age from four years old to 21 years old. Many of these children, adolescents and young adults are from families in lower income brackets who cannot afford to pay for psychological services through private clinics. Many of them are resistant to seeking psychological services through a mental health facility because of the implication of mental illness associated with the facility. These families willingly accept referrals

for the same services at school. They appreciate the convenience in accessing the services and the lack of fees.

If psychologists working in school boards were eliminated from control of the act, these children and their parents would not obtain the protection and assurances of quality of services that are provided by psychologists who are now regulated under the act.

Dr Blackstock: The second concern is that the consequences of incompetent psychological services to children are very serious and could affect the child's entire education and life, and in fact be life-threatening in some cases, of which we will give a concrete example at the end.

Children do not refer themselves or seek out the services of psychologists on their own. They are referred to school psychologists by school board personnel, teachers, principals, guidance counsellors, and they get services with the parents' written consent, of course. The children who are our clients are extremely vulnerable, as they are unable to make informed choices about psychological services for themselves. It is essential to provide them with high quality, regulated psychological services, and with a procedure for recourse in the event of malpractice. The exclusion of school psychologists from the Psychology Act would allow for recourse only through a court of law, which is time-consuming and costly.

Dr Beal: Our third issue is that psychological services provided to children by school psychologists are, for the most part, the same services provided by psychologists in health care facilities. Psychologists who work in schools provide psychological assessment and diagnosis, individual and group psychotherapy, counselling and consultative services to children and their families. They also receive preventive programs to prevent the development of mental health problems. Our referral questions cover a wide range of psychological problems which include learning disabilities and problems, behaviour problems, debilitating fears and anxieties, depression, suicidal thoughts and gestures, and social problems.

The psychological services we provide for children in schools have a profound impact on the physical and mental health, and on the educational future, of the children who are our clients, and on their parents as well. These services should be regulated by the Psychology Act and RHPA, whether they are delivered in schools or hospitals or clinics or private practice offices.

Mr Blackstock: The exclusion of psychologists in school boards from the Psychology Act could lead to the replacement of qualified psychologists in schools by unqualified teachers who are given the mandate to provide psychological services to children.

Under the current Psychologists Registration Act, psychological services can be offered only by or under the supervision of duly registered psychologists. Accordingly, the Ministry of Education has determined that psychological services may be provided in school boards only by a registered psychologist or a qualified person working under his or her supervision. Individual school boards under pressure to retain teachers where enrolments are declining may be especially anxious to replace psychologists with teachers.

The act as it now reads deregulates psychologists working in schools, eliminating the requirement that school boards offer psychological services through a registered psychologist.

Under the current language in the proposed legislation, teachers could call themselves consultants in psychology, or could offer psychological services, psychological assessments and psychological diagnosis. In fact, they could call themselves psychologists, as long as they did not offer health care services, which are undefined in legislation. The public, and especially the most vulnerable segments of the public, would not be able to distinguish between registered psychologists and those unqualified consultants, or between regulated psychological services and the services provided by those consultants. The public's awareness of the nature and quality of the service being provided to them would be diminished. Public protection would likewise diminish, rather than increase.

To make it concrete and real, here are two very brief case studies of what could happen. Imagine a school board somewhere in Ontario where, for various reasons, the department of psychological services—the people who work there—had been replaced. These registered psychologists, regulated psychologists, are gone and they are replaced by teachers. A student comes to the school board in grade 3 from some country far away. He speaks a different language, has a very different culture, and his family is struggling to adapt to a new country. It is obvious that he needs an assessment to adjust, and to deal with learning problems that he is exhibiting. This well-motivated, well-meaning teacher, who is identified as a consultant in psychology, who is working for the department of psychological services, does an assessment and, not being trained in making differential diagnosis and all the subtleties and the difficulties in making an assessment of a culturally different person, concludes that this student is a slow learner. It goes to an IPRC committee, and the student is placed in a class for slow learners. That is a very possible scenario.

1150

The second scenario happens seven years later when the same student is exhibiting severe depression, emotional problems, and the family is very concerned about it and goes to the family physician. The family physician, in his or her wisdom, says, "You should see a psychologist." The family, although they are doing well, cannot afford a private psychologist because, unbelievable as it may be, psychologists are still not covered under OHIP. They have a memory of the psychological services department in the school board and they get referred to the school psychologist who, you will remember, is a teacher who has been reassigned, rather than a trained, competent and regulated psychologist.

Depression and severe emotional difficulties are often difficult to recognize and diagnose in adolescents, especially when they are culturally different adolescents. This practitioner does not catch the fact that there is a severe depression going on and that there is a very high risk for suicide, and says so, which increases the family's feeling of helplessness and hopelessness, and the child's feeling of helplessness and hopelessness, and he could end up by killing himself. That is a possible scenario under the present legislation.

Dr Beal: Our concerns centre on subsection 15(1) of the proposed Psychology Act. We have two alternative suggestions that we have outlined in our brief, and I will touch on them lightly.

Our first one is that we encourage the restriction of the title "psychologist" or any descriptor like "psychological" to persons who are registered or regulated under the act. We would see that as being less confusing to the public and providing a greater accountability of the profession, or people who allege to provide those services.

The alternative is to broaden that section of the Psychology Act so as to include psychologists who do not offer what we call health care services to individuals by dint of where they work, if they work, say, in an educational setting, to include those people under the act, to leave the profession of psychology as an intact profession and not split it in terms of regulation, in terms of where you work. Some people who practise as psychologists in school boards also provide private practice services to the public. By wearing one hat in one job and another in another, it could be quite confusing.

Dr Blackstock: I appreciate the opportunity to make the presentation and urge you to adopt some of the proposed amendments to subsection 15(1) of the Psychology Act. Thank you. We are open to questions.

Mr J. Wilson: I think you make a very good point. It has been made before about subsection 15(1). You also point out that the health profession legislation review did not recommend the phrase "providing health care to individuals," so perhaps I could ask, once again, the parliamentary assistant: How did this phrase creep, or what is the reasoning behind this phrase creeping, into the legislation?

The Chair: Mr Wessinger?

Mr Wessinger: I will ask counsel to indicate the answer to that.

Ms Bohnen: The review did not include legislative counsel or any legislative draftsman on its team. The way it proceeded was by developing the concepts, such as concepts of title protection, and then, where there was existing language or boilerplate available from other statutes, in this case basically from the Health Disciplines Act, inserting that into the recommendations.

The review was certainly aware that these recommendations, which comprised its report, would be transformed into proper statutory language by legislative counsel in the Ministry of the Attorney General. In the course of that transformation, it became apparent that there ought to be an anchor for these title provisions. Although this was legislation dealing with regulation of health professions and protection of the public when they obtain health services, there did not seem to be an appropriate anchor for the title protection. Just as, for example, the controlled acts refer to activities done in the course of providing health care services, it appeared desirable to anchor the title protection to the provision of health care, because that is where the potential for harm in misrepresentation to the public seemed to arise. That is why the phrase was inserted into the legislation.

Mr Owens: One of the issues that this committee dealt with during the session after Christmas was the issue of children's mental health services, trying to determine where the access point for these services should be. If we decide to use the school system as the point of entry for services, do you see this legislation as inhibiting that access?

Dr Blackstock: That is a good question. We very much support the notion of providing children's mental health services in the school setting for a variety of reasons. It speaks to the need for those psychologists who are identified as school psychologists, or on the staff of departments of psychological services, to be regulated psychologists—trained, qualified psychologists rather than teachers. If teachers are permitted to call themselves psychologists or psychological consultants and, in fact, those mental health services shift to a school setting—which we think is very appropriate—there is, I think, a great danger that there be a temptation to provide those mental health services by the untrained, unqualified practitioners.

Mr Owens: Is this currently the practice to have teachers as psychologists or psychological consultants, or is this a scenario that you have developed to emphasize your point?

Dr Blackstock: In some cases, in some school boards, there are, in fact, people called "teacher diagnosticians" who do some of the psychological services. We were very concerned about that, because our personal experience is that awful errors get made by teacher diagnosticians who are asked to do a psychological assessment. It is happening now in a few places in the province, but not generally. Generally, the departments of psychology are peopled by registered psychologists and their associates. We are very happy with it.

Mr Beer: I would like to go back to Mr Wilson's question, if I could, to the parliamentary assistant, and I want to read subsection 15(2) in relationship to subsection 15(1). My question would be: If we took the example of somebody in a school board using the title "psychologist," although he or she was not, in fact, a member of the college, how would 15(2) apply to that person in terms of seeing that that did not happen, and affording the kind of protection that has been of concern here?

Mr Wessinger: I will ask counsel to reply to that one.

Ms Bohnen: As you point out with your question, there is still the prohibition against holding oneself out as a member of the college. That holding out can be effected in a number of different ways, including inappropriate use of a title or other indicia of what one's qualifications are.

I would just add, it is not the purpose of the title protection provisions to, let us say, restrict a school board in who it employs to provide particular services. The issue ought not to be: Amend these title provisions so that school boards cannot hire psychometrists, or teachers, to provide a service that they need to provide to their pupils. The issue ought to be only: What titles and representations can these non-psychologists be permitted to employ? Often the issues are melded. The review was aware of the fact that sometimes title issues become the forum for fights

over who should be providing service. It is important to keep them separate.

I just point that out because I see in the submission that concern about school boards employing non-psychologists to provide services. That may indeed be a concern, but I do not think that it is helpful to this committee to deal with that concern in the context of title protection.

Mr J. Wilson: The concern is providing psychological services.

Ms Bohnen: There are two issues. How you describe the service and who ought to provide the service. I am just saying, let us try to keep them separate.

Mrs McLeod: Madam Chairman, just as a point of clarification relating to the information legal counsel provided the committee with in Ottawa, that nevertheless, the application of the act—the holding out as well as the carrying out of controlled acts—applies outside health care institutions.

1200

Ms Bohnen: Absolutely. The scope of practice of psychology which is the anchor for the title protection as an instance of the provision of health care, is not restricted to hospitals or traditional health care settings. Much clinical psychology clearly takes place in educational settings.

The Chair: Thank you very much for appearing before the committee today. I know you are aware that you can continue to communicate with the committee in writing at any time through our clerk.

I would now like to call the Committee for Independence in Living and Breathing. While the deputation is arranging the microphones so that they can begin their presentation, I would just point out once again to committee members that you can submit questions in writing to the ministry staff if you want to prepare for the discussions we are likely going to be having around these kinds of specific issues on September 16 and 17, and that you can, at any time over the course of the deliberations, request from the ministry staff answers to your questions in writing. Often there are members who have questions that we just do not have time to get on the Hansard during the presentation. There is the opportunity for those questions to be responded to in a number of different ways. The committee members can directly ask those questions in writing of committee staff and they are then part of the public record of our deliberations.

COMMITTEE FOR INDEPENDENCE IN LIVING AND BREATHING

Mr T. Wagner: My name is Tom Wagner. I have been a ventilator user for eight and a half years during which time I have been living in the community at my family home with a part-time attendant, and I am a student at York University.

Mr McLellan: My name is Jack McLellan. Eight years ago this Friday I dived into a swimming pool in my backyard and broke my neck. I spent two years at Sunnybrook ICU, that is the intensive care unit, where I was ventilated and I still am ventilated at night. I have spent the last six years in Whitby General Hospital in chronic care,

where my colleagues' average age is about 82 years old. As a result, everything is geared to that geriatric crowd and I would sure like to get out of there.

One of the problems is because I use a ventilator, and it brings with it so many restrictions that it is almost impossible for me to get out in the community. I think I will let Margaret carry on from there.

Mrs M. Wagner: I am Margaret Wagner. Jack and I are the co-chairs of the Committee for Independence in Living and Breathing. By virtue of the name relationship, you probably guessed that I happen to be Tom's mother, which is incidental—he is an adult, he is in charge. I am providing some care when the attendants are not there and I am also a health professional who is a strong advocate for community living and for disabled people.

Mr MacPherson: I am Steve MacPherson. I am a founding member of CILB. I too had a diving accident. I breathe with phrenic nerve pacers 24 hours a day, and just this year moved out of West Park Hospital into an attendant care support service project.

Mrs M. Wagner: Our committee is approximately one third ventilator users, closing up to 50% rapidly. All of these people are living in the community and looking for better opportunities in the community. What we are here for is to talk about barriers that we hope will not be added to and make things more difficult.

Tom and I attended the seminar on July 28 that was held to discuss this law. At the seminar we had the fortune of meeting other people who had common interests, and on the one-page summary of our brief you will see that there were quite a number of agencies involved. We met on the morning of August 9 at the Ontario Medical Association and we spent two hours drafting the one sentence which is in bold print partway down the page there. The various colleges and associations took this wording back to their associations. They are in agreement with it, and as well, the respiratory therapists, physiotherapists, occupational therapists, etc., have also been approached. They are in agreement with this wording.

The difficulty that we have rests with paragraphs 26(2)5 and 26(2)6, which talk about controlled acts, etc. So our statement is recommended as an addition to section 26, subsection (4), as I said, a separate addition to the act. We feel that limiting the performance of controlled acts to specific professional persons impacts very strongly on the rights of persons to choose who looks after them, to choose what care they are given, to choose where they live, and to generally control their own lives.

Mr McLellan: In my case I do a lot of volunteer work for various organizations. I am the spokesperson for the March of Dimes again this year, and I will be going out with a speaking bureau. While I am out I will be depending upon other March of Dimes volunteers to help me get around, opening doors and driving my van. Because I am unable to cough, I require a mechanical device, a suction kit, to clear my lungs of any mucus, so I depend on the same persons to perform that suctioning for me, after some instruction from me and under my direct supervision. This law will certainly impinge on that, and that would be a terrible restriction on me.

Mr MacPherson: What we are really concerned about is the that we do not need or want to be protected by others. We do not want our care needs defined by others, and we do not want those who give our care defined by others. But we do want control of our lives and to be self-directed. This has a profound impact on where we live, where we work, our education and recreation.

Just this summer I went up north to the family cottage area. It was a cottage that my mum had actually rented where I was looked after by family and friends. We are concerned that in the laws or in the acts or even the regulations, we may lose the ability to do just as you would do to yourself. Because we are restricted with our physical disabilities we rely on other people to help us out.

Mrs M. Wagner: I would like to read a paragraph from an article which is attached to our brief. The article was written by one of our members who is an administrative consultant at the Hugh MacMillan centre. She is a committee member and is also a ventilator user.

We have been asked many times why we are so concerned about this. We are concerned because we see what is happening elsewhere when the law, which is not intended to cause a barrier for handicapped people, ends up doing so.

This paragraph says: "Comparable professional territorialization is happening in Manitoba and in New York. A few months ago Concepts of Independence, an independent living centre attendant service in New York, which has been successfully administered for 10 years by its tracheostomized and ventilated consumers"—I know some of these people; they are running a tight ship—"received seven citations to cease and desist use of attendants for such procedures as catheterization, suctioning and changing trachea tubes."

We are afraid that ultimately, without the protection of the law, this could happen here. I do not believe that was the intent of what is happening, but we have seen it happen elsewhere and therefore our concerns are great. We have yet to hear from our friends what is happening as the outcome of these seven citations. They are carrying on at the moment, in spite of the citations, and they have won a couple of deferrals. But we do not know what the outcome is, and the question is, why should they go through this?

We are, I think, open for questions.

1210

The Chair: Thank you very much for a very important and articulate presentation before the committee. We have heard from a number of consumers of services and I think you have made the point about your desire as consumers for independence and control very well. I know that is the desire of all the members of this committee from all three caucuses.

Mr Beer: Thank you for your presentation. Steve, I am delighted to hear that all your struggles at West Park have resulted in you being on your own, as it were. I think, too, I would want to say that the work you have done with others in drafting this amendment that you are putting to us is one that we have been told was coming, and so we are very pleased to get it, and support the intent of what you are trying to do, because clearly we do want to make sure that you can live independently.

I wonder if you might, for the record, share with the committee how many people currently in Ontario require various kinds of breathing assistance to give us a better sense of the impact on that particular community?

Mrs M. Wagner: The answer is we do not know. There is a new coalition set up that will have a respiratory subdivision, and I know that one of their proposals is to do a two-year study on just this thing. We know of approximately 15 people in this area who are trying—Jack being one of them—to get housing that is much more amenable to independent living. As we have said, one of the biggest failures is the fear of attendant care to take over what is perceived as professional procedures and the fear of professionals to let go. I understand that fear because, as I mentioned, I am also a professional.

We are trying to gather statistics on this, as a matter of fact, but we honestly do not know because a number of them are stuck in ICUs, and they are what is commonly called a bed-blocker. They do not want to be there, the hospital does not want them there. The trick is to get them out of our hospital. So we have that group, and that is hard to get statistics on.

We also have a large number of potential ventilator users in muscular dystrophic young men, and Tom is one. We have one or two others here today who are living long lives. I do believe that 10 or 20 years of life is a worthwhile gift. We can estimate that from the statistics through the Muscular Dystrophy Association of Canada.

Another thing I feel you ought to know is that in Ontario and in Canada today people who could be ventilated are not being given that option, they are not being given the information and they are being allowed to die, partly because of other people's perception of quality of life and what is ethical. The other reason is that the people who would give that information simply do not know about it. I do not think anything upsets our committee more than to have news of other young men dying. So I cannot answer your question.

Mr Owens: I would like to thank you, along with the Chair and my colleagues, for your presentation. I especially appreciate the remarks around the situation that is occurring in New York at this time. I am always appalled and quite amazed at some of these enforcement agencies as to where they are on the cutting edge of stupidity, and these folks clearly seem to be on the leading edge.

I am just wondering what kind of response you have had from our ministry people with respect to your, I would suggest, fairly unique situation. As the Chair indicated, we have heard testimony from deputants and attendant care providers, but you have the issue around the ventilator. Have you had any type of response?

Mrs M. Wagner: We have put on a number of seminars, three to be exact, to which we have invited ministry representatives. They have come and I think they have been sympathetic.

Mr Owens: Could we ask that as a supplementary to the ministry staff?

Mr Wessenger: Yes, I will have them comment.

Mr MacPherson: The response in the Metropolitan Toronto area has been quite positive. Charles Beer would

know that. Warner Clarke has been able to suggest to our groups and to other individuals: "If you are waiting for guidelines and that to change, directly there's nothing I can do, but show me why you should be in your own apartment in the community. That is the main reason I can say yes and open up some doors."

I have met with several other people in just the last months, including Bob Rae, just to make him a little more aware of the needs out there and that things are changing slowly. But we do not want to take a big step backwards either.

Ms Bohnen: I cannot comment in general on the Ministry of Health response to concerns about independent living. The current minister and her predecessors, including this Chair, have been very clear that this legislation will not be permitted to create additional obstacles to independent living for the disabled and have committed themselves to an exception for this. The only outstanding issue has been where this exception should be placed. I participated in discussions with the people who are here today, as well as some other representatives of groups, to talk about what might be appropriate language to the exception, whether it appeared in the statute or in a regulation. I know the government is not in a position to say today whether it now believes that an exception should go into the statute.

Mr Hope: Just briefly—it is not really a question, it is a gesture—I am also the parliamentary assistant to the Ministry of Community and Social Services, which deals with the issues. Dealing with the strategies for the deinstitutionalizing and also dealing with long-term care, rest assured that your comments have been fully briefed to the minister.

The Chair: On behalf of the committee, I would like to thank you for appearing today. I think you have, as I said before, given us a very important, well articulated understanding of the need for the shift to the kind of community-based services that are possible today because of new technology and the challenges that all legislators are facing, not just in Ontario. That will be very helpful to us in our deliberations. We have said repeatedly, and I know I am speaking for all three caucuses when I say, it is the goal of this committee to ensure that your desire for independence and control is the goal this committee will do its part in achieving in this legislation.

Mr Owens: The government would like to associate itself with those remarks as well.

The Chair: As I said, I think that is a non-partisan statement clearly from all three caucuses, all members of this committee. I would be surprised if I was considered presumptuous if I said I felt that I was speaking on behalf of all members of the Legislature.

1220

STEPHEN GRIEW

The Chair: I would like to call Stephen Griew. Welcome to the standing committee on social development.

Dr Griew: May I start by apologizing for not being able to get here last week. It had nothing to do with my hearing. Facetiously, if there had been a gastroenterologist on the committee, I would have chartered a helicopter to

get here. I am very pleased to have this other opportunity. I shall speak very briefly, since the written submission that I put in summarizes what I want to say very well.

The Chair: It was distributed last week.

Dr Griew: My concern is with the proposal that prescription of hearing aids should be a controlled act. My written submission suggests four reasons why this should not be so. First, in my view it is unnecessary. Some say there is evidence that the present arrangements put the hearing-impaired of Ontario at risk. I know of no such evidence in this jurisdiction or elsewhere. I am convinced that my teenaged children daily face more danger to their hearing from their Walkmans than I do from my hearing aid, although I must say their Walkmans protect me from listening to the racket, so this also protects my hearing.

Second, far from protecting hearing aid wearers from unspecified and uncorroborated dangers, making the prescription of these aids a controlled act would, I believe, place the hearing-impaired at real risk, the risk of having aids prescribed that would be less than satisfactory to their needs. I elaborate on this assertion in my written submission, and I can simply summarize now by saying that I agree with many who believe that with few exceptions, clinical audiologists are simply not as good as hearing aid practitioners at prescribing hearing aids that accommodate the highly individual circumstances of the individual user.

My third concern is one that I believe has not really received sufficient exposure in this debate. This is the consequences the provision under discussion would have for the older hearing-impaired person, of which, because nature made us the way nature did, there are very large numbers. Here I speak as a professional gerontologist who has spent nearly 40 years studying aging, writing about it, working with the elderly and teaching gerontology. Again, I elaborate on this concern in my written brief. I shall simply now reiterate the main point I made there. If this provision finds its way into enacted legislation, then as sure as we are all sitting here today, it will have the effect of deterring senior citizens from seeking the relief offered by hearing aids and, if I may say so, with grievously tragic consequences for the quality of their lives.

My last concern is about cost and accessibility. Some plausible arguments have been advanced to downplay the cost implications of making the prescription of hearing aids a controlled act while at the same time maintaining accessibility. In the absence of hard facts, it is impossible to be certain of anything, but using some quite conservative assumptions, my own figuring leads me to the conclusion that the increased direct costs of providing audiological services to those who would otherwise look to hearing instrument practitioners for the services they require, would be quite high. Add to this cost the additional cost of training additional audiologists, and it could quite easily escalate into something even higher.

I am not naïve enough to think that finding this sort of money would cripple the provincial budget, but it would be money well spent if it genuinely led to a better deal for the hearing-impaired and the elderly. It seems an awful pity to spend it when, far from improving their lot, its effect

would in fact make their lives more difficult. My own experience—I mention it in my written submission—has been that if prescription becomes a controlled act, when I next need another hearing aid, I shall take myself off to Buffalo, where I can legally obtain a prescription from a hearing instrument practitioner. My goodness, what a saving this would represent to our beleaguered health budget.

This leads me to the final point I would like to make. It is one that did not occur to me until the other night. It is this: I know of no other jurisdiction comparable with Ontario where the prescription of hearing aids is a controlled act. There are probably some; I do not know of them. Now, I do not claim to know everything about these things. As I say, there may be jurisdictions in which this restriction applies, but it does not apply in Australia, Britain and other countries in Europe I know about or in any of the states of the USA or in the provinces in Canada with which I am familiar. It may apply in the Soviet Union, though probably not for much longer in that country either. All this sharpens my concern. If it is so widely considered unnecessary elsewhere, I find it awfully difficult, really, to understand why we need it here.

There, then, are my concerns and why my ardent hope is that the provision that would make the prescription of hearing aids a controlled act will not survive into enacted legislation. Thank you. I hope I am going to be able to hear the questions.

Mr J. Wilson: I think it has been argued by audiologists that there is a risk of harm from improperly prescribed hearing aids. In your practice as a gerontologist, do you see many cases of harm caused by improperly prescribed hearing aids?

Dr Griew: I have never met one.

Mr J. Wilson: Never met one?

Mr Griew: No. I have many colleagues who have worked in this field; I have many friends who wear hearing aids. I have not yet come across a single case.

Mr White: And your patient satisfaction is high. I assume you are referring patients to hearing instrument practitioners.

Dr Griew: I should make it clear that I do not have patients. I am not a clinical gerontologist. I am a gerontologist who studies the process of aging and advises on the adaptation of various functions.

Mr J. Wilson: As a hearing aid user, obviously your testimony is that you have no problem with hearing instrument practitioners whatsoever.

Dr Griew: None at all. I would dearly like to see the evidence that some people say there is. I have not found it myself, and this is not the one to trick me.

Mr J. Wilson: Good point.

The Chair: Thank you very much for your presentation. We appreciate your presentation. We appreciate your appearing before the committee today. If there is additional information or data that you think might be helpful to committee members, please feel free to submit it to us through our clerk during the course of our deliberations. We are pleased that you were able to reschedule so that you could appear today.

The committee recessed at 1228.

AFTERNOON SITTING

The committee resumed at 1404.

ONTARIO FEDERATION OF
COMMUNITY MENTAL HEALTH
AND ADDICTION PROGRAMS

The Chair: I would like to call, first, Ontario Federation of Community Mental Health and Addiction Programs. Welcome.

Mr Howse: I am Greg Howse representing the board of directors of the Ontario Federation of Community Mental Health and Addiction Programs and the executive director of Simcoe Outreach Services in Barrie, which is an assessment service for people who suffer the effects of addictions.

The Ontario Federation of Community Mental Health and Addiction Programs is an independent organization of programs funded by the Ministry of Health, the community mental health branch. The federation represents over 180 organizations, employing approximately 2,400 people who provide services to mentally ill individuals and their families and to individuals suffering the effects of drug and alcohol abuse.

The first meeting of the federation was in July 1985. There was a series of meetings of successively larger groups of agency representatives who met to share resources and explore common issues. It was discovered that the issues faced were the same regardless of the nature of the agency, its service or its location. The issues were independent of the individual manager and were in fact the issues of the service organizations and the broader system.

A provincial association of organizations was needed to represent the interests of community mental health service providers and address their systemic issues. No such association existed to represent these agencies although a relatively small number, 34 or less than 10%, were Canadian Mental Health Association branches associated with the Ontario division of the CMHA.

By 1986, the federation was a voluntary non-profit corporation with over 170 member organizations from across Ontario. This included the Ontario division of CMHA and most of the branches. As each member organization typically had more than one service program, this represented approximately 70% of all funded community mental health services in Ontario.

In the same time period, addiction services of various types were transferred into the adult community mental health branch's jurisdiction. Given that the interests and issues of the federation were systemic and related to administration and funding by the ACMH branch, the addiction programs were welcomed into the federation and the name changed to reflect this constituency.

The federation envisions a community mental health and addiction system which exists to assist and support people: to achieve their potential; to enjoy a positive and productive lifestyle, and to live, participate, and contribute in their communities.

Members of the federation support the legislation but we have two concerns. The first concern is paragraph 26(2)1 of Bill 43, the controlled act. That is: "Communicating to the individual or his or her personal representative a

conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual..."

The Ministry of Health has created a system for addictions treatment in Ontario. The hubs of the system are assessment and referral centres and there are around 34 of them in the province today. These programs were established to assess individuals' addictions to alcohol or other drugs. As many of you are aware, there is a great debate about whether alcoholism is a disease. In fact, the Supreme Court in the United States is being asked to decide the very question. If alcoholism is not a disease, it is certainly a disorder or a dysfunction. The issue that the managers of the assessment services have here is: How do we communicate to individuals after completing an assessment if it is prohibited by this legislation?

1410

Similar experiences will occur in the mental health services. Treatment services for outpatient mental health in the province are staffed by social workers and other non-regulated professionals. Once again, the function of many of these staff is to relate to individuals or their representatives findings in regard to a disease, disorder or dysfunction. Some services could perhaps circumvent the law by having a psychiatrist on staff, but this is merely a way of getting around things. Staff in housing programs for psychiatric patients can and do talk to individuals about how they are functioning. If a staff person notices symptoms increasing and gives some advice to the client based on these observations, would that person be in jeopardy of prosecution because the client places a great deal of reliance on the advice of this unregulated professional?

In our working life, staff in mental health and addiction systems often relate to individuals their conclusions about disease, disorder or dysfunction. In fact, if this section is proclaimed, staff could be breaking the law and liable to fine or imprisonment. A number of individuals involved in the process indicated that there is no intent to close down existing programs. The concern, though, is what would judges think if the section was proclaimed as it is written?

Another concern of the federation was subsection 27.04 in the original drafting of the document which was presented in 1989, in other words, the harm document. The federation would like to reinforce the fact that this section has been removed and it should not be reintroduced. The harm section, as it was written, would in all likelihood create more havoc in the mental health and addictions field because the section talks about offering treatment or advice. In our business, on a daily basis, if not treat, we certainly offer advice to individuals. They do, I am sure, rely on that advice.

I would urge you then not to reintroduce the harm clause. That is my presentation.

Mr Owens: My question is for ministry staff, through the parliamentary assistant. My understanding is that, in terms of the order in which people seek treatment for their addictions, probably one of the last groups they see are physicians. They would seek out help from centres such as

this first, or through a pastor or a family member. How would this legislation under the diagnosis clause impact, in the ministry's opinion, on the types of services these addiction centres would be carrying out?

Mr Wessenger: I will ask staff to elaborate on that.

Ms Bohnen: I think it is important to distinguish between the two forms of assistance. First there is an individual seeking assistance with his behaviour—drinking too much, being addicted to a substance, be it alcohol or some other substance—and appropriately, as you say, following the usual course of seeking assistance from non-medical people, volunteers, professional addiction counsellors and so on. We do not believe the legislation would infringe on that.

However, if an individual in addition to, or instead of, being aware of an addiction problem, suffers from physical symptoms such as—I am not expert enough to know what some of the physical signs of addiction might be, but let's say signs of liver disease, more neurological symptoms, seizures, things like that, I think the Ministry of Health would expect an individual with those physical symptoms to seek medical assistance to determine whether the symptoms of his liver disease are related to his addiction, or if he has some other problem. In any event, those symptoms will need medical management.

This will not force people to go first and only to physicians for assistance with their addiction, but rather, yes, people will go to counsellors for addiction counselling and behavioural change and, yes, will continue to go to physicians where they also have medical problems related to their addiction.

Mr Owens: If I can ask a supplementary, how would that relate to the psychiatric problems which can stem from addictions? I am not sure where I am heading on this but I just sense there is a real problem in separating the organic or the physiological addiction from the psychological aspect of the issue.

Ms Bohnen: Remember, it is not as if this legislation were being put in place in a void. There is a functioning system that will continue to function, and I guess a minority of people will go to psychiatrists or their family physicians for help with the psychiatric symptoms of their addictions and most people will not. Most people will go to addiction counsellors, Alcoholics Anonymous and other agencies like that. That will not change.

Mr Beer: Having a better sense of what it is you are doing on a day-to-day basis, in looking at your activities today, the role you play in working with a physician, with the people who come into your centre—I would see you are working primarily within a context where a diagnosis had been made by a psychiatrist, or in some setting such as that. While you would continue to communicate and discuss various things, in no real sense could one say you were making the diagnosis, but rather that it was an assessment, and so on. How do you work today, and can you relate that to the concerns you expressed, and its impact on you if this went through?

Mr Howse: A simple accounting which I can relate to you: We have had 800 people referred in the last year for an addiction problem, a number of them referred by family

physicians, for example, who want us to determine the extent of their addiction. My concern is that I am communicating to an individual the extent of that addiction, and that is the wording in the legislation, or the proposed legislation, "communicating." It does not say "diagnosis." The old legislation maybe talked about diagnosis; this one just says "communicating a conclusion."

We, as unregulated professionals, often communicate conclusions to individuals for physicians, for example. Physicians do not have the expertise that we do in regard to alcohol and other drugs, and their psychological impact. They do not have the time to sit down. Our assessment takes upwards of three hours to complete. We are looking at not only physiological, but school or work issues; we are looking at education issues; we are looking at home life; we are looking at problems with the law.

It is a psychosocial examination, a psychosocial assessment, it is not only physiological. That is only one part of the entire spectrum of problems people get into when they become addicted to drugs or alcohol.

Mr Hope: My question, I guess, is going to be a contentious one, but I want to pose it to you. It is not only through marijuana and other things, there is also substance abuse and drug abuse through prescribed drugs. That is really going to jeopardize what is reflected in the Martin report dealing with the disabled community and the seniors. If an individual says, "I am feeling very anti-depressed, or hyped up; I am addicted to something," how is that going to work with the medical model, prescribing medication and at the same time pulling the person off that medication because of the addiction aspect.

1420

Mr Howse: We are often dealing with individuals who have been using Valium, for example, for 20-odd years and they come to us and say, "I want to get off." The manuals that drug companies put out say, "Use it no more than two weeks." Another drug is Halcion, which is a sleeping pill. "Use no more than two weeks," and people have been on it for years. They come to us and they say, "I do not want to be on this medication any more." We have to get the doctor on side, and it is usually not a problem. It effectively begins a process, in conjunction with physicians, of weaning people off these medications that may not be necessary. We find it an awful lot as well in the psychiatric client who is taking multitudes of drugs. People are taking drugs to combat symptoms of the drug they are taking for their psychosis, for example.

There is a number of reports, especially with women who are prescribed antidepressants—women are not necessarily depressed—and not only antidepressants but Valium and Librium as well. Women are coming to us and saying, "Look, I want to operate in society without these drugs. Can you help?" As I say, we talk to the physician, or the patient will talk to the physician and say, "Look, I am working with Simcoe Outreach Services, and I want to get off these drugs." They are usually quite co-operative.

Mr Hope: Your diagnosis refers to the drug that is causing the symptoms that the individual has?

Mr Howse: Yes.

The Chair: Thank you very much for your presentation before the committee today. I have told most of the deputations that if you think of anything over the course of our deliberations that you feel might be helpful, or any information that you receive, please feel free to communicate with us in writing through our clerk.

LABOURERS LOCAL 183
MEMBERS' BENEFIT FUND

The Chair: I would now like to call Mr Murray Gold of the Labourers Local 183 Members' Benefit Fund.

Mr Gold: The 183 Members' Benefit Fund is a multi-employer, jointly trustee, labour-management health and welfare fund, one that delivers a variety of health and welfare benefits to members of the Labourers' International Union of North America, Local 183.

In 1979 it established a dental clinic as one means to deliver dental services in the most cost-effective, yet high-quality mode they could design. At this point, the clinic is a substantial consumer of dental services. We are looking at about 15,000 patients a year who receive dental services in a manner that is suitable for them, in their own languages, and hours that are suitable to them, through a staff that comprises qualified professional practitioners including a dental administrator, 13 dentists, three dental hygienists, 19 dental assistants and six receptionists and other clerical staff.

The clinic itself delivers most dental services at its own premises at 1136 Dupont Street—all the basic services. It maintains relationships with outside professionals for specialized services, people like orthodontists and periodontists.

The clinic, to our knowledge, is a unique institution in Ontario, being a creature of the collective bargaining process, having participation from both labour and management, and delivering services as a large organized consumer of these professional dental services. In this way, it is able to obtain dental services at preferred rates because it offers practitioners a very steady workload, and does not compromise at all on the quality of delivery. Since it is a non-profit organization, the full benefit of those economies are passed on to the members.

The perspective that we bring today is that of a large consumer of dental services, and we would just like to go over three areas where we have encountered some concern, and to draw those to your attention, particularly how the legislation would influence those areas.

First of all, with respect to dental hygienists: Until the onset of this recession, the clinic experienced a chronic shortage of dental hygienists. We were simply not able to hire the number of dental hygienists we needed. As a consequence, dentists were hired to perform basic work, cleaning and scaling and conducting preliminary examinations that could easily have been performed by dental hygienists at a much lower cost. The recession has eased this supply crunch, but our fear is that it is temporary and once the recession lifts we will again be confronted with a shortage of hygienists.

So we look to this legislation to see whether it puts in place institutions, rules and procedures that will allow the system to produce an adequate supply of dental hygienists. Our experience has been that the existing system for

regulating supply is not adequate, and when we look at the new legislation we see a potential role for the advisory council. We see that its role as an independent third party in the health care process should be greatly enhanced. It should be given a much more directed consumer protection mandate. Certainly one of the things we think they should be doing is monitoring the supply of health care professionals. This arises directly out of our concern and our experience with dental hygienists, but I am sure the observation can be applied more broadly.

We would anticipate that, in reaching conclusions with respect to supply, the advisory council could consult with organizations such as our own and with others so policy-makers have a much firmer sense of where shortages are and what can be done about them.

With respect to dentists, we have had one major concern develop over the past years. That relates to the necessity for us to compensate dentists on a fee-for-service basis. The reason we are compelled to pay a fee for service rather than to employ dentists on a salary basis is because of the rules of professional conduct adopted by the Royal College of Dental Surgeons of Ontario. They stipulate that it is professional misconduct for a dentist to be employed by an organization other than a government or a government agency or alternatively by a dentist. So we as a private clinic cannot employ dentists; we must engage them only on a fee-for-service basis and that has proved to be extremely expensive.

When we look at the Health Professions Procedural Code, we see in section 90 that the councils regulating the various health care professions are still empowered to pass bylaws governing codes of ethics, that there is no requirement for prior ministerial approval, nor is there a requirement for the Lieutenant Governor in Council to approve the amendment pertaining to code of ethics until after it has been passed.

We would suggest this is not appropriate and because measures contained in codes of ethics can be used to restrict supply or influence fee schedules, protect fee arrangements, any regulations pertaining to codes of professional ethics should be made only under section 91 of the Health Professions Procedural Code. If that change were made, then each such amendment would have to receive prior ministerial approval and would also require the approval of the Lieutenant Governor in Council before becoming effective. We see this as a very important issue.

Finally, with respect to dental specialists, the biggest issue we have encountered, the most significant one, is cost. We do not supply orthodontal and periodontal services directly, but we have relationships with outside contractors, with outside professionals, and we know through our experience this has been very expensive for them and that most consumers of dental services cannot afford to retain orthodontists and periodontists. The reasons for the expense in this area may be several and may relate to the shortage of training spaces that are funded or the costs of specialized education after one goes through the dental program. We do not pretend the problem has a simple solution, but we do say it is a very serious one because orthodontal and periodontal specialist services are not accessible to a great number of people because of the cost of those services.

Once again we would urge a much stronger role for the advisory council in this area, a much stronger consumer protection role that would empower and mandate the council to investigate and develop recommendations to make these special services more accessible to ordinary consumers.

1430

Our conclusions, our recommendations, are simple. We would urge that the advisory council's mandate under section 11 be expanded so that it has an express consumer protection mandate to promote consumer access to private health care at affordable prices, to monitor the supply of, and demand for health care professionals, to make recommendations to the minister with respect to such regulatory educational funding changes as may be required in order to meet consumer demand at affordable prices, and to review the impact of technological change on the appropriate division of responsibilities between health care professionals such as hygienists and dentists, for example.

We would also recommend that councils not be able to pass bylaws with respect to professional ethical standards without prior ministerial approval, and that the power to pass such regulations be transferred from section 90 of the code to section 91 so that prior ministerial approval and approval by the Lieutenant Governor in Council will be required prior to the amendment being effective.

Mr Wessenger: I think we can give you some clarification on some of the points you raised. I am going to ask legislative counsel to do that now.

Ms Bohnen: This concerns the point you raised about the prohibition in the dental regulation forbidding dentists to work as employees of most agencies. In fact that prohibition appears in the definition of professional misconduct, not in a code of ethics. Under this legislation, as under the Health Disciplines Act, it is a regulation that the minister must give prior review to and must be approved by the Lieutenant Governor in Council. Once this legislation is in place, all of these regulations will eventually be reviewed by the Health Professions Regulatory Advisory Council in any event: so it may be that your concern that they get public government scrutiny and review will be achieved that way.

Mr Gold: I did not appreciate that. Thank you for that clarification.

The Chair: If there is any additional information you have that you think would be helpful to committee members, we would appreciate it if you would communicate with us in writing. Thank you.

CANADIAN SOCIETY FOR ENVIRONMENTAL MEDICINE

The Chair: I would like to call the Canadian Society for Environmental Medicine.

Dr Krop: I am Dr Jozef Krop, representing the Canadian Society for Environmental Medicine as their secretary and advocate, together with Dr Phillip Bright, treasurer. Briefly, the purpose of our society, set out in more detail in appendix B to this submission, is to promote the good health and wellbeing of the people of Ontario through the improvement of the environment in which they live, and

through promotion of public understanding and awareness of the effect of the environment on the state of human health.

Specifically, we are advocating today the inclusion of the following clause which is modelled on recently introduced legislation in the state of Alaska, namely:

"No disciplinary body of any college constituted under the RHPA, as a regulatory body, may base a finding of professional incompetence or negligence or failure to maintain the standards of the profession, solely on the basis that a registrant's practice is experimental or unconventional, in the absence of demonstrable physical harm to a patient."

Other jurisdictions have also recently enacted similar legislation. Samples of analogous legislation are appended hereto in appendix A. Other states, such as California, Texas, New York and New Jersey are in the process of preparing similar legislation.

Our rationale for inclusion of this clause is consistent with the principles of freedom of choice and freedom to be innovative inherent in the tradition of western society. Both patient and doctor should have access to treatment modalities judged on their efficacy, not on whether they fit current dogma. We are aware that the present government, like the physician members of our society, is concerned about four aspects of health care: first, enhancement of quality of care; second, enhanced protection of the public; third, increased attention to the role of environmental factors in health, and fourth, improved cost-benefit ratio in health care delivery.

These are high priorities and intimately interwoven with our core objectives as a society and as individual practitioners. We believe they are also parts of the agenda that are accorded a high priority with the present government, as well as the opposition parties. We will demonstrate briefly below, in terms of the scientific literature and other monographs available, how we believe that inclusion of the above proposed clauses can be beneficial in achieving these objectives.

The first would be enhancement of the quality of care. Appropriate concern for, and working knowledge of, the principles of environmental medicine are present in the government. In 1984, in response to growing public concern about hypersensitivity of some individuals to environmental exposures, the Ontario Ministry of Health established a committee to study environmental hypersensitivity disorder, chaired by Judge George Thomson, the present Deputy Minister of Labour and the principal author of its report published in 1985. It is attached in appendix C. Since its publication, the working operational definition of the syndrome known as environmental hypersensitivity syndrome, found on page 17 of the report, has become a standard, comprehensible to the lay person, sufficiently precise for the professional, and cited repeatedly in subsequent reports and texts as the authoritative definition.

The committee's chapter on professional debate, page 266, indicated their increasing dismay "at the polarized and adversarial positions being taken in the United States on the issue" and unease at increasing realization "that the same hardening of attitude is taking place in Ontario." They also believed that "confidence in the health care system is eroded when productive dialogue between different

medical specialists disappears, or is replaced by acrimonious debate before a confused public."

One way out of this dilemma is through the inclusion of the clause referred to above, which could provide an atmosphere of openness and sharing of information among health practitioners from different backgrounds, training and practice profiles. It would eliminate the fear of practitioners to explore new modalities of treatment.

1440

A correct understanding of environmental hypersensitivity disorder would eliminate the unnecessary stigma of psychiatric or psychosomatic diagnosis attached to those suffering the disorder. With further understanding and education, the medical profession, company doctors, and WCB physicians would be able to recognize the valid grounds that environmentally sensitive patients have for collecting disability pensions. Similarly, secondary insurance carriers would recognize the necessity to reimburse appropriate therapists.

The Ministry of Health could continue to be a leader in funding research, interdisciplinary conferences and education efforts. The salient distinctions between belief systems and approaches of environmental medicine and other medical approaches is summarized on page 22 of Ashford and Miller's book, *Chemical Exposures: Low Levels, High Stakes*, based on their report to the New Jersey State Department of Health in 1989, the whole of which is attached hereto as appendix D.

Implementation of their recommendation in chapter 6, page 147, would, we believe, result in a higher level of protection of the public. That brings us to our next heading, which is "Enhanced Protection of the Public." The biggest single issue under this heading is freedom of choice by patients to select the practitioner of their choice. Our responsibility, in participating each in his or her own way in this legislative process, is to frame legislation in which all models and aspects of diagnosis and treatment are presented to the patient so that he or she can make informed choices.

The model used by environmental physicians is to involve the patient in the process of diagnosis and choice of treatment as much as possible, and to empower him or her to participate as the partner in the healing process. Our model is not paternalistic or authoritarian. Each individual has multiple variables influencing his or her health. It is advantageous for the patient to assist in formulating the plan of care so that commitment can be made to following through in improving the level of health. This is the basis for preventive medicine.

We know today that approximately 20% of patients seek complementary or non-allopathic healing methods, such as acupuncture, homeopathy and nutritional therapy. If physicians felt free to learn about other modes of therapy, some worthwhile and complementary techniques could be developed. Such treatment could be administered—or at least monitored—by the licensed physician with a special interest in these areas to avoid risk of harm to the patient.

Protection of the public implies protecting the rights of the physician in any of the medical disciplines to investigate and initiate new ideas and modalities of diagnosis or

treatment in order to improve the quality of health of his or her patient, without fear of censure by colleagues. The inclusion of the proposed clause may also encourage physician interest groups to call on the College of Physicians and Surgeons of Ontario to assist in developing and disseminating helpful guidelines for practice in the new or difficult areas of medicine.

This leads us to the third aspect of health care, which is increased attention to the role of environmental factors in health. We are sure that this committee is aware of growing evidence that environmental pollution affects not only the health of the trees and other animal species, but of humans as well. From the ozone holes to acid rain to organophosphate pesticides to toxic dumping to the sick-building syndrome and electromagnetic radiation, there is an overwhelming link between our polluted environment and the increase in chronic debilitating disease leading to lower productivity, poor quality of life and skyrocketing health care costs. Some material from the World Commission on Environment and Development relating to this is appended as appendix G.

Indeed, the former minister, and chairperson of this very committee, Mrs Elinor Caplan, said, and I quote, "Unlike the contagious diseases of old, the major health threats our society faces are largely attributable to environmental and lifestyle concerns." Doctors' offices are filled with patients complaining of chronic fatigue, insomnia, memory disorders, difficulties in concentration in certain environments, chronic depressions, muscle and joint aches, gastro-intestinal disorders, etc. Greater recognition has been given to the role of environmental factors in recent years.

In addition to the previously mentioned report of Thomson's committee, there is also a Survey of the Medical Impact on Environmentally Sensitive People of a Change in Habitat, by Dr Barron, in 1990, as research for the Canada Mortgage and Housing Corp., appended hereto as appendix E, as well as a January 1991 report of the proceedings of the Environmental Sensitivities Workshop, a publication of Health and Welfare Canada, which is appended as appendix F.

Every major employer and educational institution in Ontario could benefit from the knowledge gathered by researchers and practitioners of environmental medicine. Inclusion of the proposed clause would free all regulated practitioners to learn about the environmental impact on health, exchange ideas and information, and implement effective and available treatment modalities in their practices.

The last aspect of health care with which every Ontarian is concerned is improved cost-benefit ratio in health delivery. Prescriptions, genetic engineering and more transplants will not solve the underlying causes either to our health disorders or health budget problems. An ounce of prevention is still worth more than a pound of cure. While much cost-benefit research dwells exclusively on the fiscal consequences of different health care delivery plans, we are concerned also that the social and health benefits to the patients are increased.

Environmental physicians emphasize the uniqueness of each patient. We begin with a detailed environmental history of the patient which is often sufficient to discover the cause of ailment and reduce the need for costly and potentially

dangerous X-rays and tests, not to mention treatments. We counsel patients in a healthier lifestyle and diet, indicating ways to clean their immediate environment at home and seek co-operation in an environmental assessment at the workplace or school to determine and reduce the total toxic load, including such factors as electromagnetic radiation, moulds, air, water and noise pollution, to make these places safer, healthier and more productive.

We are also put in the position of having to act as patient advocates to assist in obtaining reimbursements for out-of-the-country treatment and/or other social benefits which are routinely available to patients using conventional treatments. Our time and expertise, as well as public money, could be better spent by incorporating the principles of environmental medicine to the disciplines of community health centres and setting up an environmental health unit in Ontario so that patients who are acutely sensitive do not need to travel to the United States or England for specialized treatment.

The cost-effectiveness of employing environmental medicine is staggering. Studies in appendix H show that the two goals of lower costs and increased benefits can be harmoniously and simultaneously achieved. We feel that inclusion of the proposed clause would improve a multilevelled and multidisciplinary approach to helping patients lead fuller lives, which is in total harmony with the recently published report of the Premier's Council on Health Strategy.

1450

In conclusion, we heartily underline all of the recommendations in the eight appendices attached to this submission, drawing them to your attention in this format and recommending them again. We feel that inclusion of the clause as set out in the preamble and handout will be a concrete step in achieving the best health care for Ontarians. It will free every responsible health practitioner and informed patient to seek the treatment model best suited to individual patient needs. Madam Chairperson, this is our conclusion and we invite any questions.

The Chair: Thank you very much for your presentation. We appreciate you coming before the committee today. A very thoughtful brief. If you have any additional information, I know that you will feel free to submit it to the committee.

Mr Jackson: I notice you acknowledge the jurisdiction of Alaska as having recognized the unique nature of environmental health concerns. Are there any other jurisdictions that you can reference? I have not had the opportunity to go through, but if you could just for the record indicate those.

Dr Krop: Exactly the same legislation was put through in the state of Washington. Excerpts from it are in appendix A. To my information, New Jersey, New York, Texas and California are looking to do the same thing.

Mr Jackson: Any off-continent, to your knowledge?

Dr Krop: No, but there is one different approach to this problem. I am from eastern Europe and there, as a medical practitioner, I was free to implement any type of therapy, as long as that therapy did not harm the patient. I

think it would be very important if this country had the same type of system.

Dr Bright: This is probably true in Britain, where complementary systems do work hand in hand. For example, in the national health care system there are not only allopathic hospitals but also homoeopathic hospitals and they function side by side. In fact, the royal family is a great supporter of homoeopathic techniques and treatments. I think basically there may be a slightly more enlightened atmosphere in Europe than there is at this time in North America and Canada.

Mr Jackson: I am familiar with the Yugoslavian health care system. That is an obscure story, but I am quite familiar with their interrelationship and some of the work they have done in this area. I just wondered if they were moving to a more regulatory model or if it is simply the success of certain modalities and their ability to work side by side with "more traditional forms of medicine."

Dr Krop: I am not aware of all these things. But recently I was involved in an environmental conference which was organized from here in Canada, with some participants from the United States and Japan, and took place in Poland. They at the present time are looking into the creation of a department of environmental medicine in their medical school, since they recognize the great impact of pollution on the health of the people. We have been very welcome there because we gave them a different understanding of the problems. They are looking mostly at toxicity. We here are looking from the point of view of toxicity and sensitivity, they did not realize yet, but I think it will come.

Mr Jackson: For the record, I want to indicate that the Halton Board of Education was the first school board in Ontario to develop an environmentally sensitive teaching environment, and it is very successful. It is very expensive, but it is very successful in allowing children in Halton region, and other children who are brought in, to experience their education without illnesses. So we are moving towards that.

The Chair: Thank you very much, Mr Jackson.

Mr Jackson: Thank you. I knew you were interested.

COLON THERAPISTS ASSOCIATION OF ONTARIO

The Chair: I would like to call next the Colon Therapists Association of Ontario.

Ms Towns: I am Barbara Towns. I am a registered nurse and a colon therapist. I represent the Colon Therapists Association of Ontario. Colon therapy is a topic that is often difficult to talk about. People do not like to talk about having bowel movements, but this is what this treatment is about. We colon therapists do cleansing of the large intestine. It may make some people feel uncomfortable to have this conversation, but it is necessary.

There are about 500 colon therapists in Canada, about 150 in Ontario. I have been a colon therapist for 10 years. I have seen thousands of patients. There is a great concern being brought to our attention from the patients themselves that it may come to pass, in the very near future, that they

may not be able to get the therapy they want and need unless it is ordered by a physician.

The last time I spoke before this committee—not this whole committee but some of the people here—I brought forth the idea that most medical doctors do not know much about colon therapy. They do not know how it is performed. They do not know why it is done or why patients get a colonic. But across the board, because it is an alternative therapy, they pretty much say that it is not beneficial and advise their patients against it. In effect, if it comes to pass that a patient will only be able to get a colonic if a physician orders it, basically they are not going to be able to get a colonic.

There are several concerns we have and I could understand that a body such as this would have them. It is an invasive therapy in some ways. We use water that is introduced into the bowel, very gently, but it is done at this point in time by a variety of different people. I am an RN. Some colon therapists are registered nurses. There are laypeople doing colonic irrigations at this time.

We have appealed to the Ministry of Health to be recognized and regulated. We have not had much satisfaction in that line. We feel this is important. This is a safe treatment, as many treatments are, when it is done properly, when there is proper surgical sterilization, when the technique is done in a gentle and judicious manner. Any treatment is detrimental if it is not done properly; so part of what this paper you are now getting has attempted to do is to put forth how we believe this treatment can be conducted in a safe manner.

Mr Basen: May I interject here? My name is Lionel Basen. We have met Mrs Caplan and Linda. I am the chairman of this group, the Natural Therapies and Products Coalition. We represent a number of groups, the colon therapists being one of them. They are the one we are the most concerned about, because the new legislation is going to put this therapy, which has been around some 3,500 years—this is not a new whacko type of money-making venture; it has been around for 3,500 years. It was practised by the medical profession up to something like 40 to 45 years ago; it was practised at St Michael's Hospital. It has not been proven to be a bad treatment; it is just not the type of treatment the average medical doctor today feels comfortable with. He would much prefer to give tablets and do surgery and the up-to-date types of treatment, as opposed to suggesting that you get a super-duper enema, which in effect is what this is. It is certainly more than that—it is washing of the complete colon.

1500

The presentation you have in front of you explains the—I was going to say the ins and the outs but—general therapy. We are very concerned that if the legislation goes through as suggested, the medical profession will have, again, complete control of a situation they do not believe in, much like osteopathy and many other things that over the years they have taken control over. And it will die in its legal form. It will not stop it; it will still take place, just as abortions take place. We are talking about something certainly much removed from that, but it would be the same

situation. It would go underground. It would still be there; it just would not be controlled. It would not in any way be regulated, and we are very concerned about that.

What we are looking for is an exemption, just as you have exempted acupuncture, or are in the process of exempting acupuncture. We certainly would look to having some form of regulation in the future. We would like to enter into negotiation with the ministry because we feel that anything that is taken by the general public requires some control. However, this is not control; this is wiping it out. The users of this therapy have a very real fear that it is going to become illegal.

Ms Towns: I am a simple colon therapist. I am a nurse. I love my work. I do this every single day. I have been doing it for 10 years. It is the most rewarding work that I have ever done. This is why I became a nurse. This is preventive medicine. I spend most of my day helping people learn how to eat properly and eliminate properly.

If it comes to pass that only a physician can order this, many people who go to their physicians with simple problems like gas or because they have a bowel movement only once a week, when they go their physicians, usually the doctor will tell them to take Metamucil or to eat more fiber, and that is it. He sends them on their way. A lot of people that I have coming in to see me, say: "Now what do I do? I still can't go. I don't want to take laxatives. I don't want to get dependent on enemas." And this is very different.

There is a distinction between an enema and a colonic. With an enema, you fill up with a large amount of water and you retain that water for a period of time, generally 5, 10, 15 minutes. That stretches the bowel wall and if you do this over a prolonged period of time, the elasticity of the wall may become damaged, so that people can actually become dependent on enemas. Perfectly honestly, if a colonic was done in an injudicious manner over a long period of time, a very long treatment, possibly a person could become addicted to a colonic as well, and only be able to have a bowel movement after colonic. That is not proper technique. When it is done properly, a colonic is actually a wash. The water flows in and the water flows out, and it carries the waste away. It actually stimulates the wall of the bowel.

I am going to give you a few examples. I hope you are not completely grossed out by this, but I have an older woman who came to me, and who for 40 years had been constipated. She had been to her doctor and he told her to take laxatives and Metamucil. She tried everything, and she was still constipated, some days better, some days not so good. After three treatments, she came back and said, "This is it?" She is going every single day. Three measly little treatments. Now, that was not only the colonic. I also talked to her about simple things, eating, drinking water, having some salad and getting the bowel cleaned out enough so she could have regular movements. I have not seen her in months. She came back one time—this was several years ago—and said, "I went out and did some things, ate cheese and so on," and she got constipated again and went on her merry way again. This woman said: "I suffered for 40 years; I didn't have to. Why didn't someone else ever tell me this, after all the complaints I have had and gone to doctors?"

If the physicians would only listen to their patients. Being a nurse, this is adjunctive to and a part of medical treatment as far as I am concerned, but it does not have to be exclusive to medical treatment. I think that is the point. The Canadian public should be able to decide to some degree what types of treatments they need and want. They should not have to have a Big Brother doctor telling them it is okay for them to get a colonic irrigation. I think a lot of the patients I have spoken to find that personally insulting and degrading.

Mr Johnson: I find this presentation particularly interesting. In fact, the whole process of these hearings has been particularly interesting and most educational. I did not know anything about colonic hydrotherapy until I heard it today. I certainly am aware of what enemas are and I know they have been around for a long time as well.

You mention a very important fact, that personal health education is very important. I do not want to misinterpret this, but it sounds like this could be, rather than preventive, more an answer to a problem, but that may not be so.

I am curious to know how many people—because I have never heard of this before; None of my colleagues or friends say, “Boy, I had a great colonic therapy today”—I was wondering how widespread is this knowledge and how frequent; you said 150 in Ontario, but where is this practised most widely?

Ms Towns: Toronto. In Ontario, the bigger communities certainly have the greater population. I have been doing this for 10 years in Toronto. I see on average around 60 patients a week, maybe 70. Now this is turnover, this is not—

Mr Johnson: They are not repeats.

Ms Towns: No, they may come for one, two or three treatments and then they are on their merry way. So there is quite a large turnover of people. This is not something that is discussed a lot. People wait until they know somebody really well before they tell them. You may know people who have had colonics, they just have not told you that they have had them.

Mr Johnson: It is not something you discuss around the dinner table.

Ms Towns: No, but it does make people feel really good.

Mr Jackson: I am familiar with the procedure and I was anxious to know the basis of your referrals, since the primary concern here is the referral base and the limitations on referrals. Give us a quick run-down of where you get your referrals now and how much of that is medically referred.

Ms Towns: The referral generally is word of mouth. We do not advertise. When I started working at the clinic we put one flyer out saying we had opened, that was it. Everything else has been one person telling another person. In the 10 years I have been working I have had maybe three referrals from a doctor. One was a man who had a barium enema. They found a mass in the barium enema; they could not get the barium to go in. The man was familiar with colonics and asked his physician if it would be okay, before they did surgery, which was what they were recommending, if he could have a series of colonics and then have another barium enema. That was one of the

referrals. The man did not have a tumour, it was merely impaction. His next barium enema was completely clear. The man did not have to have surgery.

Mr Jackson: I am familiar with some of these stories and I wonder whom you have talked to in terms of this legislation, officially, from the government and what feedback have you gotten on the subject. Whom have you approached and what have they said?

1510

Ms Towns: The only other meeting we have had was in 1989 with the Ministry of Health.

Mr Basen: Mrs Caplan was there and Linda Bohnen and a variety of other people from the ministry, and Alan Burrows. We had explained the situation and, as you are probably aware, there was a lot of reluctance to change many parts of this legislation. There was a catch-all phrase in there that virtually made anything other than the 24 groups illegal. That catch-all phrase has been dropped. I do not think it was intentional. I understood the reason it was in there, but unfortunately the ministry did not realize when it put it, in the extent of the damage it could do.

We understand the reluctance to have some sort of exemption for colonic therapy. It is not wrong to have regulation for it, but to wipe it out is another story. We would like exemption for a time and we would like very much to sit down with the ministry and work out some area where it makes it as safe a situation as it can be. Giving aspirin is not a safe situation; giving herbs in the health food store is not a safe situation. There is some risk with virtually anything you do. There is not a lot of risk with colonics.

Mrs McLeod: I will ask two very brief questions. First of all, would you be able to tell me specifically which controlled acts prohibit your practice independently?

Mr Basen: The medical act.

Mrs McLeod: But there are a number of specifically controlled acts under the—

Mr Basen: Any invasive procedure, anything beyond the anal verge.

Mrs McLeod: I was quickly trying to read through the brief you have presented. You have indicated a number of areas in which colonic hydrotherapy would be indicated and a number of others in which it would be indicated under prescription and direct supervision, as well as contraindications. I wonder if you could say a word about how you can make decisions whether it is indicated only with supervision or whether it is not indicated at all without full diagnostic procedures.

Ms Towns: The majority of people who come for a colonic generally come because they are constipated. People who come with some type of bowel disorder, colitis, Crohn's disease, they usually have been to a physician already and have been diagnosed. Those people would definitely be sent back to their physician to have the physician okay that treatment.

Generally it has been my experience that people who are having severe bowel problems do not come to us first. They seek help from their physicians. Certainly we would never do a colonic on someone who has had bleeding or

who had severe pain. I think it would be a judgement that would be made by the therapist, hopefully a therapist who is properly educated and has a sense of the severity of the situation. Generally, the way they are taught is that when in doubt, just do not do it.

The Chair: Thank you very much for your presentation before the committee today. I know you are aware that if there is additional information you would like to present to the committee you can do so in writing through the course of our deliberations.

ATTENDANT CARE ACTION COALITION PLUS

The Chair: I would like to call now Attendant Care Action Coalition Plus. Please introduce yourselves to the committee. I am aware that you have some written material that will be submitted following your presentation.

Mr Parker: My name is Ian Parker and I am a consumer of attendant services. Before I refer to the few pages of my paper, I want to say that I was injured in a diving accident in 1974. I dived into a lake and hit the bottom of a beach. I spent a year, which is typical—or maybe on the short side, actually—in hospitals and in rehabilitation hospital. Since 1975 I have lived in the community and fairly independently as well, receiving and organizing attendants to do things for me that I cannot physically do with my own hands, since I do not have good use of my hands. By the way, were I injured just slightly farther down in my back rather than my neck, I would still be requiring some of the kinds of procedures that I use, yet I would have good hands and be able to do them for myself. So I have in front of me someone who acts as my hands for me.

I worked for the Ontario government, for a few years and especially in 1981, the international year of disabled persons. That is 10 years ago now and I invented the slogan, "Label Us Able" at that time, which was the slogan for the whole government to show how able disabled people really are. I do not want to be sensational, but I fear that if the bill goes through it might in some ways leave us saying, "Label us sick" and I think that would be a really unfortunate and unintentional achievement of the bill.

I am here on behalf of the Attendant Care Action Coalition Plus. We are a coalition of consumers of attendant services and supporting organizations across Ontario who want to bring about improvements and new options in attendant care services or attendant services for persons with physical disabilities. We want our attendant services. My colleague, Hazel Self, is handing out copies of my paper. I will continue.

Attendant services, as I said, are essentially what people do for me, acting as my own hands and legs. In our case, the responsibility for what is done lies with us, the consumers. The onus regarding how things are done, when they are done and whether they are done to my satisfaction and to the quality I need, rests with me. It does not rest with anybody else or any organization which may help organize the services I use.

By the way, both Hazel and I are on the board of directors of an organization which arranges attendant services, so we see the issue from many sides. We see the issues from the

side of consumers as well as organizers and the people who are legally responsible for such services.

Why are we here? Well, it is the perception of many of our members and related organizations that Bill 43, the Regulated Health Professions Act as currently worded, appears to intrude on some common and long-standing practices in attendant services, and they are indeed long-standing. People have had attendant services at least since the end of the Second World War and they have been publicly funded in Ontario at least since the mid-1970s.

There is a perception that Bill 43 appears to apply to attendant services. The bill is perceived, rightly or wrongly, by general readers to do two things: (1) to define putting an instrument, hand or finger beyond bodily orifices as controlled acts, and (2) to place a restriction on those acts that they may be performed only by authorized health professionals. That in fact is not the intention of the bill. The general reader does not see that this definition and restriction of controlled acts applies only in the course of providing health care, so there is the distinction: health services, attendant services.

The people involved with attendant services, whether consumers, attendants, managers, board members or insurance companies, will generally be led to believe that the bill is making these acts illegal for attendants to perform.

There is at present no clarification to the contrary in the bill. For example, it is not explicit that certain acts in the course of providing attendant services, not being health care, would therefore be exempted. Indeed, there is no definition of health care in the bill anyway, so confusion naturally arises about the limits of its scope.

1520

The bill identifies certain procedures as controlled acts in health care, but it should be spelled out that these very same procedures are carried out in attendant services as—and this is important—routine practices with a history of government policy and government funding. There would be a real danger if these acts, through silence in the bill, were generally misunderstood to be medical or health care acts alone. Further, it would be a disaster if these acts were then made illegal in attendant services.

It is unfortunate that a lack of clarity about the limits of health care is involved here, because it is an issue that hits too close to home for people who have disabilities—I am on page 3 if you wish to look, the last paragraph—and where, after all the public education campaigns, there still exists confusion about our health status in the minds of the general public. It is not known widely enough that many disabled people have for a long time lived very independently of medical systems and institutionalized services, and we want to remain independent and in control of our own services.

Disabled persons living in the community are neither sick nor do we wish to be perceived as such, and this act gives the perception of such. That is why it is a danger to us. The routines we as individuals perform daily or have assistance to perform, are routine activities of living for us. We do not want them to be defined as medical acts or controlled acts or health care.

What controlled acts are involved in attendant services? Well, the procedures we are talking about here include, for example, going to the toilet and urination. Going to toilet by suppositories or enemas or other methods, using a catheter for urination, maintaining assisted breathing or even things like inserting a tampon. Some people simply cannot do it for themselves. These are the kinds of things that are totally routine within the daily lives of many people who have disabilities.

There is quite a spinoff already to the confusion which exists. It is happening already that, in new organizations or where medical people have a say in management or on the boards of these organizations, they now believe it is illegal to provide attendants for bowel and bladder care. They believe their insurance will not cover them. Confusion is currently causing some organizations, especially in the north, to deny consumers routine bowel and bladder assistance, or to set up their services in such a way that they do not provide that. This causes, of course, stress and inflexibility to the consumer. It really makes their lifestyle dependent on somebody else rather than having the same person get them dressed who would help them on the toilet or help make their lunch. If you have to wait around for somebody else to come in and do something, it causes a lot of problems and also causes the inflexibility of having to wait for some so-called professional person, whereas if it is an attendant whom we train ourselves, they are much more available to us to suit our own lifestyles. It could also put attendants out of work and cause considerable expense to the public purse.

While we wish to see an amendment in the bill, we have been promised regulation, but we do not feel that is sufficient. The bill, after all, is the first and last reading many people around attendant services will do. It is imperative that the bill be clear. It would be grossly unjust in the bill to define as illegal what disabled people have for years done daily. Regulation would require consultation and discussion all over again. Regulation does not give us protection from the minister's pen, any changes could be made in the future. It is just not fair to make it appear these are medical acts where in the past they were not medical acts.

Who supports our amendment? We have a long list here. ACAC Plus drafted it together with the Ontario Medical Association, the College of Nurses of Ontario, the Centre for Independent Living in Toronto, the Advocacy Resource Centre for the Handicapped, the Committee for Independence in Living and Breathing, and a representative from the Ministry of Community and Social Services. In addition, it is endorsed by the Registered Nurses' Association of Ontario, the Ontario Physiotherapy Association, the Ontario Society of Occupational Therapists, Cheshire Homes Foundation, the Clarendon Foundation, whom you heard yesterday, Three Trilliums Community Place, whom you have heard. It is also endorsed, I am quite sure, by most other organizations involved with attendant services. Our amendment is listed at the top of the next page.

Subsection 26(4): "An act by a person which comes within paragraph 5 or 6 of subsection (2) is not a contravention of subsection (1) if the act is done in the course of providing for a person physical assistance with routine

activities of living which the person would otherwise do if the person were able to do so."

Why is the amendment in the public interest? It would correct the confusion which unintentionally is now created. It would recognize the important role that consumers attach to attendant services. Attendant services work as they are. The quality of service is good because it is tailored by the individual to meet his or her own individual needs. The consumer is satisfied with questions of health, safety, and, as I have said, we would be severely limited otherwise. The cost to the taxpayer of any other system would far outweigh what we have now. Hazel, would you say a few words?

Miss Self: I have been using the attendant services for 12 years. I have spinal cord injury, and therefore I have an indwelling Foley catheter which drains the bladder. I train my own attendants or anyone to assist me with that, and already I am getting questions saying, "Well, am I still allowed to do this?" or "Is it illegal for me?" This is what is happening at the grass-roots level. As Ian said, it was never the intention of the bill, of course, to produce this sort of meaning, but this is how people are interpreting it. Over the last 12 years, there has never been one problem with one person who has assisted me in this procedure. But they are very worried, so we want to see this thing taken care of in a way that I can point to it and say, "Look, it's okay, you can carry on what you're doing," and I can live happily ever after.

Mrs McLeod: Your amendment seems like an eminently sensible and clearly written way of dealing with the problem. Can I ask you directly whether there have been any objections raised about the specific wording of the amendment you propose?

Mr Parker: No, there have not. It was put before those organizations on our behalf by the Ontario Medical Association, and there have not been any changes in the wording whatsoever.

Mr Hope: How do you rest assured that quality assurance is there, in some of the day-to-day routines? How do you know whether you are getting the proper service?

Miss Self: It is in my hands. The quality is in my hands. I direct the person assisting me step by step, and that is how I want the quality to be, resting with me. It is my responsibility. That is the whole foundation of attendant services. That is how it was formulated in the beginning. That was the arrangement with the ministry. That is what it has been built on. For people receiving the service, one of the main priorities of eligibility is that you do direct. As soon as you pass responsibility over to the person providing assistance, it changes the whole scene, and it does not work that way anyway. I want to be the one in control.

Mr Hope: What I was getting at specifically is dealing with the insertion of the catheter.

Miss Self: Maybe I will describe that, because that is a clear example. In a hospital, for example, it is taught as a very sterile procedure. It is certainly done by a registered nurse or someone qualified to do it. They are responsible for the outcome, and the patient is a passive recipient of what is happening. In my situation, I do not use the same

procedure at all; it is just a clean technique. Basically, I pay for the catheters, which are \$15 apiece. You do not throw them out each time. I change it every day. In fact, I reuse them, which you would never do in hospital. My technique is totally different. I have never had a bladder infection in 12 years. I have never had antibiotics or been hospitalized.

[530]

So when you are looking at quality, it is not relating to a sterile, taught procedure; you are looking at other things. You are looking at basic things like competence. What we are always having to prove at every debate and every discussion is that, yes, I could show anyone step by step. It is my competence I am always having to justify and prove.

Mr Parker: The important distinction, I think, is that in a hospital, most of the people there are unstable care. It can go wrong, because they are not stable, whereas we have been doing it for so many years, learned how to do it in hospital, and it is just so routine it is second-nature to us that we know what we are doing. In fact, if we were to go into a hospital, we would be training the people there to do our way.

The Chair: Thank you very much for an excellent and thoughtful presentation. I believe it is very helpful for members of the committee to hear directly from consumers, and we have heard a number of presentations similar to yours. With each one, we have assured the presenters that it is the goal of all the members of this committee to ensure both the independence, as well as the personal control, that you have identified, to be sure that this legislation does not impede that. We appreciate the work that you have done in developing an amendment which will be considered by the committee.

KAREN KAHANSKY; STEFAN FRIDRIKSSON

The Chair: I would like to call Karen Kahansky and Stefan Fridriksson. The committee has received the documentation that you presented to the clerk, and it becomes part of the public record.

Ms Kahansky: Since audiologists are the ones requesting hearing aid prescription as a legislative act, it is up to us to demonstrate that the public is better served with this legislation than without it. The two main issues I would like to address today are overamplification and middle ear pathologies requiring medical intervention.

With regard to middle ear pathologies, there are certain danger signs that are readily apparent to the trained eye through an otoscope. If, for example, a middle ear infection remains undetected, complications that can arise include perforation of the ear drum, cholesteatoma, facial paralysis, brain abscess, meningitis or permanent sensory neural hearing loss. In his letter to this committee, Dr Mendelsohn states that only university-trained professionals be allowed to prescribe hearing aids, as we have the necessary training in the anatomy of the ear.

Deterioration of hearing due to overamplification has been so well documented in the literature that it is now considered indisputable. In addition, ear specialists have clinically reported aggravated tinnitus due to overamplification.

Thus far, I have limited this discussion to the possible physical harm that can result from incomplete assessments and inappropriate hearing aid prescriptions. In closing, I would like to leave you with the question, what about the social devastation of an incorrectly fit hearing aid?

Mr Fridriksson: In 1987, audiologists accepted the grandfathering of all hearing aid dealers who were prescribing hearing aids at that time. Because we accepted the grandfathering, we now find ourselves in the position where we must prove that future hearing aid dealers do not deserve the same right.

We ask ourselves, why would this committee allow hearing aid dealers to prescribe hearing aids? Is it because they are well-trained? In defence of their skills, they told you that some of their members had graduated from a one-year training program at Sheridan College. This implies that a college training program would be adequate training for the prescription of a medical device. This notion contradicts the consensus report of the 1990 Vanderbilt international symposium on hearing aid prescription. In reference to the necessary qualifications, the opening words of the conference's consensus statement are, "The first decision that must be addressed when prescribing a hearing aid is whether a person is a candidate for a hearing aid." This statement implies audiologic diagnosis.

The prescription of a medical device requires that someone make a diagnosis. It has been clearly stated by physicians that they rely on audiologists to make the diagnosis of a hearing loss. Every day, they send me patients for these diagnoses. None of these patients wear labels proclaiming their ailment. They might have normal hearing, chronic middle ear disease, a dead ear, a middle ear malignancy or even a brain stem tumour.

How do hearing aid dealers propose to separate the routine hearing losses from the ones that require further evaluation? They are not trained in differential diagnosis, site-of-lesion testing, case history analysis, medico-legal testing or use of clinical equipment. This training is not to be had in the college training curricula. In the arsenal of the hearing aid dealer, they have but one skill and one solution for a hearing loss: Fit a hearing aid on it. And they do.

Is there potential harm in allowing hearing aid dealers to prescribe a hearing aid? I have letters from ear specialists documenting cases of hearing aid dealers fitting all of the above types of hearing loss with hearing aids. I have letters from seven eminent authors and researchers documenting cases of harm caused by hearing aid misprescription and overamplification.

Is it because hearing aid dealers have demonstrated skills that impress other professionals? It is their lack of skill that prompted the WCB, Metro social services and virtually every insurance company in Canada to require an audiologist's prescription prior to a hearing aid fitting. In his letter, Dr Wilfred Goodman, an ear specialist and the WCB's chief adjudicator, asks this committee if it is appropriate to allow opticians to prescribe eyeglasses. Obviously not. Then why, he wonders, would you consider it appropriate to allow a hearing aid dealer to prescribe a hearing aid?

Is it because experts from the field have told you that hearing aid dealers are qualified to prescribe hearing aids?

I have letters from the chief otologists of seven major Metropolitan Toronto hospitals, and promises of letters from six more, urging you, in the interests of the protection of the public, to give the exclusive, licensed act of hearing aid prescription to audiologists. I have letters from internationally recognized authors and researchers telling you that audiologists are the only professionals with the skill and knowledge necessary to prescribe a hearing aid. Despite all of this, audiologists are still willing to honour the 1987 grandfathering.

As MPPs you can determine the standards of health care in a field you know very little about. Hearing loss is a disease that deserves to be taken seriously. Audiologists are asking you to do just that.

The Chair: Thank you very much for your presentation. I know you realize that if there is any additional information you think would be helpful, you can submit that to the committee in writing, although we did receive your very substantial brief.

Mr Fridriksson: We have left five minutes for questions.

The Chair: Yes. There are none.

Mr Fridriksson: No questions? Can I address some questions to you?

The Chair: If you wish. You can always submit them in writing.

Mr Fridriksson: If I could just say them?

The Chair: Sure.

Mr Fridriksson: I spoke to all the different heads of the otology departments in the Metropolitan Toronto hospitals and some in the Ottawa hospitals, and they were concerned that we are about to allow this to happen. As you will see in their letters, there are so many cases. It is not just an isolated case of a brain tumour being fitted or a middle ear malignancy being fitted or a middle ear disease that has been fitted with an occluded ear mould that causes the middle ear malignancy to continue or to become a brain abscess or something like that. These are not isolated cases.

The Chair: I would not interpret the fact that there are no questions from committee members as any bias one way or the other.

Mr Fridriksson: No, I understand.

The Chair: We have had a number of presentations.

Mr Fridriksson: Addressing the same issue?

The Chair: Yes. I can assure you the committee is well aware of this issue. They have heard it. They have received the documentation. It is recorded in Hansard.

Mr Fridriksson: Excellent.

The Chair: So do not feel because there are no questions that in any way you have not been heard.

Mrs McLeod will make you feel better. She has a question.

Mrs McLeod: I am just wondering, because of the concern you have just reiterated in wanting to add those

last comments, whether you have had some clear indication that the proposals that are currently in legislative form would be changed.

Mr Fridriksson: I am worried that somehow future hearing aid dealers will be allowed to do to my patients what I have seen. Yesterday I saw a man, 82 years old, have a hearing aid fit on a dead ear.

Mrs McLeod: But you have not had any indication that this would in fact be allowed?

1540

Mr Fridriksson: I am concerned. The presentations I heard last time that there is no possible harm from misprescribing a hearing aid—I wanted to clarify that there are so many cases. I am worried—obviously not for my sake; I do not wear a hearing aid—but for my patients' sake I am worried. I am worried that somebody is going to get killed. I mean it. I have a letter from one of the doctors who came that close with a patient in Orangeville, and I am worried that another patient could go through the same thing she went through: two months of really bad pain from a middle ear being fit.

The woman had chronic middle ear infection and she was fit on that ear despite the fact that she told the hearing aid dealer she had chronic ear infections. She was assured that it would not hurt. She was fit on that ear and two weeks later she had the smelliest ear. You would have to stand that far away with your otoscope to look in there. I am worried that this kind of thing will continue.

Mrs McLeod: But if the legislation goes through as proposed, your concerns are addressed.

Mr Fridriksson: I want it to go through as it is proposed, and I want you also to notice the letters. I have 62 of them personally written to me saying that they support diagnosis of hearing loss and its communication. Last time I had not read as clearly as I should have, and I said that some of them did not specifically state that they wanted us to communicate our diagnosis. But I have clarification letters from every single doctor who wrote me a letter, a total of 62 doctors. If every audiologist in the province went around and collected them—259 times, and let's say we each got 15 or something like that—it is obvious the medical community wants us to tell the patient they have a hearing loss. We are the ones who diagnose it; we should be the ones to say, "You have a hearing loss" and explain it.

The Chair: I can assure you that you have been very clear on the position you have put forward. We appreciate the documentation you have provided us with.

Mr Fridriksson: Thanks for your time. There is some more documentation.

The Chair: Just submit it to the clerk, and if over the course of our deliberations there is additional information, we are happy to receive that at any time.

The committee adjourned at 1542.

CONTENTS

Wednesday 28 August 1991

Regulated Health Professions Act, 1991, and companion legislation / Loi de 1991 sur les professions de la santé réglementées	
et les projets de loi qui l'accompagnent	S-705
Association of Social Work Directors of the Hospital Council of Metropolitan Toronto	S-705
College of Physicians and Surgeons of Ontario	S-707
Task Force on Sexual Abuse of Patients	S-710
College of Optometrists of Ontario	S-714
Association of Chief Psychologists of Ontario School Boards	S-717
Committee for Independence in Living and Breathing	S-719
Stephen Griew	S-721
Ontario Federation of Community Mental Health and Addiction Programs	S-723
Labourers Local 183 Members' Benefit Fund	S-725
Canadian Society for Environmental Medicine	S-726
Ontario Therapists Association of Ontario	S-728
Attendant Care Action Coalition Plus	S-731
Arren Kahansky and Stefan Fridriksson	S-733

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of Ontario**

First Session, 35th Parliament

**Official Report
of Debates
(Hansard)**

Thursday 29 August 1991

**Standing committee on
social development**

Regulated Health
Professions Act, 1991
and companion legislation

**Assemblée législative
de l'Ontario**

Première session, 35^e législature

**Journal
des débats
(Hansard)**

Le jeudi 29 août 1991

**Comité permanent des
affaires sociales**

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent



Chair: Elinor Caplan
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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Thursday 29 August 1991

The committee met at 0918 in the Water Tower Inn, Sault Ste Marie.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

ALGOMA CHILD AND YOUTH SERVICES

The Chair: I call first Algoma Child and Youth Services. You have 20 minutes for your presentation and for any questions members might have.

Dr Cheston: Thank you for the opportunity to pronounce our concerns with the proposed Regulated Health Professions Act and the Psychology Act. We are from Algoma Child and Youth Services. I am Dr Patricia Cheston. These are my colleagues Dr Alan Gelmych and Dr Jay McGrory. We also have presenting with us Deborah Brooks, who is a member of the Ontario Board of Examiners in Psychology. She is a public representative.

We would like to express our agreement with the direction of the proposed legislation. We are comforted by the fact that many professionals who are currently unregulated will now be regulated. Due to fewer resources, it is our opinion that rural areas such as ours in northern Ontario are more vulnerable to unregulated individuals practising and being viewed as psychologists. We were going to address the issue of psychologists practising outside of the Ministry of Health. However, we have received information that this issue has been largely clarified for psychology.

However, we do have concerns about protection of the terms "psychology" and "psychological." We view this as a consumer protection issue, and we have invited Deborah Brooks to read a letter she has written which we feel addresses this issue.

Ms Brooks: The letter referred to was submitted to Tony Martin. My comments today are on the same topic, but they deviate slightly, as I wanted to be a little briefer. I am here today to support the petitions presented to you by the individual psychologists with respect to changes required in the proposed Regulated Health Professions Act.

I am a public member of the Ontario Board of Examiners in Psychology and have so far served in that capacity for two and a half years. I was active in special education issues in Sault Ste Marie for many years. I have served as a director of the Sault chapter of the Ontario Association for Children

with Learning Disabilities and as a member of the public school board's special education advisory committee. I am also a parent of a learning disabled child who has been on the receiving end of psychological services for most of his formative years.

It must seem incredible that a piece of legislation could go through so many years of development, be subject to so much debate and discussion, pass the microscopic inspections of dozens of legislative experts yet still be so drastically flawed. Yet with respect to the practice of psychology in Ontario, the regulated health professions legislation is flawed. Instead of strengthening public protection from unqualified, incompetent and unfit providers, it would remove from the scope of regulation and therefore from statutory accountability almost half of the psychologists who are presently registered in Ontario. This would include all those whose practices are not health care, such as educational psychologists and industrial psychologists.

Instead of improving the mechanisms which allow the public to make informed decisions when exercising freedom of choice of care providers, the proposed act would strip the terms "psychological" and "psychology" of their common usage as descriptors of a regulated practice. The public will have no consistent means of distinguishing between regulated and unregulated practitioners for either health care services or non-health-care services.

I ask you to review carefully the submissions you will receive today and those previously submitted to you by the Ontario Board of Examiners in Psychology and the Ontario Psychological Association. They present the problems with the proposed legislation much more completely and offer very sensible solutions. These are not trifling complaints, nor are they in any way self-serving to the profession. The changes which you are being asked to make are vital to the welfare of thousands of Ontario citizens who are in need of psychological care.

Dr McGrory: To summarize for many of the people who have just joined us, we are discussing some of the concerns that we as psychology professionals in Sault Ste Marie are particularly concerned about in the proposed legislation. Two key issues are, first, the issue of the application of the legislation to people outside of health; our understanding is that this may not be an issue any longer. The second issue that is clearly outstanding is one that pertains to the regulation of the terms "psychological" and "psychology," which are presently regulated terms and are not used outside of the scope of a psychologist's practice, but according to the new legislation will not be regulated.

The Ontario Psychological Association commissioned a poll and found that the public does not discriminate between the terms "psychologist," "psychological" and "psychology." If one or two of the terms are not regulated in the proposed legislation, our concern is that the consumers

and the public will not be able to discriminate and will not be able to determine which are regulated professionals and which are not. Examples, which I am sure you are aware of, would include terms such as "psychology consultant" and "psychological practitioner." Even services or centres such a psychology centre would not, in our interpretation, fall under the jurisdiction of the proposed legislation.

That is very disconcerting for us, particularly for the children and families we work with. We appreciate the opportunity to present our concern and are willing to take any questions.

Mr Martin: As we have gone through this month and heard of some of the concerns you have raised this morning, and certainly we have heard them a number of times from various organizations, a dilemma is posed for me and I think for some of the other members, and I guess it cuts to the heart of this legislation: How do we protect the public from people who are not qualified and yet how do we provide services, particularly to northern areas and remote communities, in perhaps more creative ways? The issue you bring up in terms of tightening up the language and some of the classifications may make it more difficult for northern communities to get the people they need to do the job, because we cannot all either access or afford the psychologist. Do you have any comment on that? That is a concern for me and I am sure it must be for you as you service areas around the Sault.

Dr McGrory: Clearly, we here in the north recognize that trained professionals are a rare commodity. However, legislation that would allow untrained professionals, particularly individuals, to write psychological reports, for example, to provide psychological assessment without any regulating body would not, in my opinion, be helpful to the public in general and/or solve the issue which is a current issue of being able to provide more creative or more diverse mental health services.

Mr J. Wilson: You raise a number of points I have heard before, but following on Tony's lead, I was wondering how many non-doctoral practitioners you have in the area versus PhDs, actual psychologists, registered.

Dr Cheston: You mean within psychology or within other professions?

Mr J. Wilson: We had testimony earlier that there are a number of people with MAs, for instance, practising the profession legitimately. My worry is with title protection. Although you have the terms "psychological" and "psychology" protected now, they are kind of out there, outside of this legislation. You are in negotiation with the College of Psychologists of Ontario to try to get the MAs recognized. If we go ahead and extend the protection to those terms again, we may pre-empt that process.

Dr Cheston: Currently if the MAs do psychological assessments and so forth, the reports are co-signed by a registered PhD psychologist. There is a certain quality assurance to the reports in that way. I do not see it as an issue of preventing other people from practising. I see it as an issue of giving the public more clarity in terms of whom they are seeking services from.

Mr J. Wilson: But what if the MAs who are currently trying to become members of the college are not successful over the next 18 months in negotiations. Will it effectively bar them from practising psychology? They will not be able to say they are providing psychological services, for instance, because they will not be members of the college and will not be entitled to the title protection.

Ms Brooks: I would like to comment on that. The public members of the college have identified and have raised concerns with the college over the MA issue and are very much in support of bringing an MA-level type of provision under the scope of the college; I understand there has been a draft agreement or whatever drawn up between the MA group and OPA and OBEP. But I want you to know that by removing protection from the terms "psychology" and "psychological," you water down regulation. What is needed is for the regulation to apply to a broader range of psychological services. That would be achieved by bringing the MA-level practitioners under the scope of regulation in some way. The lay persons see that as really an important issue, that the MA-level practitioners be regulated.

0930

I think the OBEP submission to you has commented on a number of complaints that come to OBEP about unregulated practitioners. The people involved are quite surprised when they find out that the psychologist or the counsellor they have been seeing is not a regulated professional. It is important that those issues be addressed.

That, when you look at it very carefully, is separate from the title issue. By not giving protection to the titles "psychology" and "psychological," it will not solve that problem. It will just make it worse. It will be more confusing.

Mr Beer: Without this protection, if someone is being hired by a school board, surely the school board knows whether that person is a psychologist and registered. Playing devil's advocate a bit, is there not a responsibility as well on the consumer, on the body that is hiring the person, to make sure that individual is indeed what he or she says he or she is, and does not subsection 15(2) also address that issue?

Dr Isbitsky: Can I respond to that?

The Chair: You will have to come to the table. Are you part of the delegation?

Dr Cheston: This is Dr Joyce Isbitsky. She is doing a presentation at 11:30.

Mr Beer: I will repeat the question later. I think we need to be clear on some of these issues, and I wonder where the balance is and why 15(2) would not provide that protection.

Ms Brooks: Having sat on tribunals where psychologists were in employment settings, there was often a conflict between the ethics and standards of conduct and practice required of a professional psychologist under the act and what his employer wishes him to do. That conflict does exist, and I have seen evidence of it in tribunals and in disciplinary proceedings.

It is not good to leave it up to employers, even if they are boards of education or hospitals or whatever. Their

interests are often not compatible with what a psychologist would consider to be ethical; for example, disclosure of information and confidentiality, to name one issue. They are in conflict.

Mr Owens: On the issue of supervision and quality assurance, it appears that the current practice is that the MA performs the assessment and then the PhD simply signs off on the assessment.

Dr Gelmych: Not necessarily.

Dr Cheston: Usually a PhD is supervising; that means he or she will go over the raw data with the MA person. The PhD person is responsible for what goes in that report and the interpretation of the data and the recommendation. Although the MA person may actually write the report, it is not a matter of just reading it and signing it off.

Mr Owens: Would that practice change and how would it change if you folks were regulated or were part of the college as the PhDs are and will be? Will that practice change at all?

Dr McGrory: If our interpretation is correct that under the legislation the terms "psychological" and "psychology" are not regulated, presumably it would mean that anybody could write a psychological report, which is what the title of our reports are now, without supervision of a psychologist.

The bottom-line issue is that certainly many MAs are quite competent and are able to do that. I do not think we are concerned with the MAs. What we are concerned with is untrained people presenting themselves as professionals, writing reports that may be construed as professional reports, but who are not regulated and with no regulating body for the consumer to respond to.

Mr Wessenger: I have a comment with respect to the whole question of providing health care. It should be understood that it is not the site where the service is provided; it is really providing health care whether that is in an educational institution or in a health facility. It really does not make any difference.

The Chair: If there is any additional information over the course of our hearings or deliberations that you think would be helpful, please feel free to submit to us in writing by our clerk.

ONTARIO PHARMACISTS' ASSOCIATION

The Chair: I call the Ontario Pharmacists' Association. You have 20 minutes for your presentation.

Mr Krall: My name is John Krall. I am the immediate past president of the Ontario Pharmacists' Association. I am presently chairman of our ad hoc committee, which has reviewed this legislation. With me today is Gary Sands, our manager of government and public affairs.

The Ontario Pharmacists' Association is a voluntary professional organization representing approximately 4,000 pharmacists in Ontario. Under enabling legislation passed in 1986, OPA negotiates with the Ministry of Health on behalf of all pharmacists for the professional fee paid to pharmacists under the Ontario drug benefit program.

On behalf of our elected council, I want to thank the committee members for this opportunity to appear before

you today and outline OPA's position on the Regulated Health Professions Act.

Notwithstanding some concerns, the Ontario Pharmacists' Association wishes to indicate its support for the proposed legislation presently known as Bill 43 and Bill 61, the Pharmacy Act.

The primary purpose of this legislation and the basis of OPA's response to it is the protection and safety of the public. Our association also accepts that the legislation was intended to strike a balance between preserving the concept of self-regulated health professions, while at the same time ensuring public accountability. It is within this context that we outline our concerns with certain sections of these bills.

Our first concern is the controlled act exemption. It is recalled from a briefing by Ministry of Health staff last year that its main objectives were to level the playing field and to make the public interest paramount. It was these principles that resulted in the designation of controlled acts along with the prohibitions set out in subsection 26(1) of Bill 43.

However, clause 39(1)(b) of the same bill allows the minister to exempt a person or activity from subsection 26(1). Our association does not comprehend the rationale for this exemption provision, nor does it accept that government interest and public interest are always convergent. The government must be subjected to the same rule of the level playing field as the professions.

The issue has been raised with Ministry of Health staff, and no explanation or rationale for the exemption provision has been given to the Ontario Pharmacists' Association.

Therefore, we would agree with the Minister of Health when she said, "The 13 controlled acts provide ample protection for consumers," and would further submit that allowing the minister to arbitrarily exempt a person or activity from the regulations that health professions will use to govern themselves does not conform to the spirit of this legislation.

0940

Under the subject of titles, the proposed legislation will ostensibly prevent any pharmacist who holds the PharmD degree or the PhD degree in pharmacy from using the title "doctor" as a vocational designation. These degrees are highly regarded by our profession, and the obtaining of such should be encouraged and appropriately recognized.

The Ontario Pharmacists' Association joins the Ontario College of Pharmacists and the Ontario branch of the Canadian Society of Hospital Pharmacists in asking the committee to amend section 30 of Bill 43 to permit duly qualified pharmacists to use the title "doctor."

Hospital exemption: Under the Health Disciplines Act, the provision of drugs in a hospital, health or custodial institutions has been exempted from the regulations laid out in the Pharmacy Act under the Health Disciplines Act. This exemption has been maintained under the proposed legislation before this committee.

The Ontario Pharmacists' Association believes that the practice of pharmacy, as defined in section 3 of Bill 61, in a hospital, health, or custodial institution must be directed by a pharmacist who is accountable to the Ontario College of Pharmacists for his or her professional activities. In the

public interest, the current blanket exemption cannot be justified, and we urge it to be amended accordingly.

The midwifery amendment: The draft amendments tabled with the committee on August 6 included an amendment to section 4 of Bill 66. One new clause will allow midwives the right to prescribe drugs. While the minister referred in her statement to an unknown "limited list of medications," our association has some reservations about this proposal.

As the report of the Pharmaceutical Inquiry of Ontario, chaired by Dr Lowy, pointed out last July, the issue of proper prescribing practices is already something that is challenging the medical profession.

Pharmacists have no objections in principle to the concept of midwives prescribing drugs. Indeed, this may represent an area where traditional medicine can utilize conventional medicine for the betterment of women.

However, we understand there is at present no specific educational program in Ontario for midwives that provides training and education in pharmacology and therapeutics. We believe an adequate knowledge of pharmacology and therapeutics is essential and that the corresponding educational requirements should be put in place for midwives.

In addition, would the right to prescribe drugs also allow for their purchase? We understand from ministry staff that this would, in fact, logically allow midwives to purchase or acquire certain drugs. This too requires clarification.

The current safeguards over the provision of drugs to the public has been accomplished through professional regulation and the rules of pharmacy ownership. A weakening of these strict controls poses serious ramifications.

We would suggest the amendment allowing the prescribing of drugs by midwives be reviewed with these points in mind. Since the minister has indicated that the regulated health professions will be continuously reviewed, we would be more than happy to participate in a further review of this amendment.

Membership of college council: The Ontario Pharmacists' Association supports self-regulation with an appropriate balance of public representation of councils. The Health Professions Legislation Review headed by Alan Schwartz stated, "Self-regulation cannot function successfully unless the individuals regulated consider it to be a fair and appropriate balance," and suggested that one third of the council membership be composed of public representation.

In March 1991, the Premier's Council on Health Strategy also made a recommendation related to public participation on governance structures, which include "governmental and quasi-governmental authorities and committees, and boards of publicly funded agencies." The council recommended in objective 2.2: "By 2000, ensure that the representation of consumers of health and social services be at least one third of the membership on governance structures."

Public membership of just under 50% poses a serious threat to the concept of self-regulation. Again, as the Schwartz review pointed out, the complex and specialized nature of professional work demands that professionals play a significant role in their own regulation.

While we appreciate that the government's intention is to increase public membership above the one-third level,

the Ontario Pharmacists' Association feels that the rationale for the recommendation of the Schwartz review and the Premier's Council should be carefully considered. We would suggest to the committee members that public membership of just under half, in a system of self-regulation, is not an appropriate balance.

I would like once again to thank you for listening to our concerns, and we certainly would welcome any questions from the committee members.

The Chair: Thank you very much for your excellent presentation.

Mr Wessenger: I would like to have ministry staff clarify a couple of the points raised in your brief.

Mr Burrows: I would like to clarify a couple of things. First, with respect to the controlled act and exemption, there must be some misunderstanding in terms of communication with the ministry, because as recently as a week ago Mr Sands and I had a discussion on this subject and I did provide him with rationale, but I am pleased to reiterate that.

I think it is important to read the whole section. Section 39 starts with, "Subject to the approval of the Lieutenant Governor in Council, the minister may make regulations," and there is more than one thing that is covered in this: "(a) prescribing forms of energy," which the committee has heard about previously; "(b) exempting a person or activity from subsection 26(1)," which is the controlled acts; "(c) attaching conditions to an exemption in a regulation made under clause (b);" and "(d) allowing the use of the title 'doctor.'" So there is a series of things.

But I would like to point out, first, that the minister alone would not make such a regulation, that these regulations would have to go through due process. In terms of due process, under this act it is envisioned that regulations of all types, regardless of their source, would be discussed and vetted by the advisory council, and the process for the advisory council is such that it would be an open and public one.

Also, the test of the public interest would have to apply. I have discussed this with legal counsel, and an arbitrary exemption would be subject possibly to review and it would have to be defended if it were challenged on the basis of the need for the public interest.

It is also envisioned that situations could develop such as a pressing need, for example, a natural disaster in an area of the province where there were not sufficient regulated professions to cope—a good example would be areas of northern Ontario—and the government must have the ability to move very quickly to approve things if such a situation were to develop.

Specifically, the need for exemption has already been brought before the committee too in such things as a simple procedure like ear-piercing, which, if there were not an exemption, would be illegal—acupuncture and so forth. So it is designed as a mechanism for flexibility.

I would also like to point out that this particular exemption has not apparently been a problematic one for most of the other health professions we have dealt with, with respect to the development of this legislation.

With respect to the midwifery amendment, I would simply like to say that what is envisioned is a situation that is not unlike that which presently prevails for optometrists. Optometrists are able to use a short list of drugs which is provided for by regulation. We would expect the same sort of thing here.

Certainly the government would not disregard the opinion of Dr Lowy with respect to the need to protect the public. It might be advisable, if the Ontario Pharmacists' Association has specific suggestions in this regard, to make its views known to the interim regulatory council on midwifery, which is charged with, among other things, working on the educational program. Clearly, if midwives are going to be authorized to use drugs, they would need some appropriate training in that regard.

Mr J. Wilson: I would like to ask about your comments on the controlled acts exemption. Is it just the inconsistency you see there that you are not pleased with, or can you give us something more concrete about how this could be detrimental?

Mr Sands: Going back to Alan, the first thing to clarify is that yes, Alan and I did discuss it last week. Unfortunately, the brief had already gone to the council for approval. They still felt it was contrary to the spirit of the act, and we had corresponded with the branch a couple of times and had no explanation or rationale received. But the opinion of the council is that it still feels that mechanism is contrary to the spirit of such a regulation.

0950

Mr Beer: I would like to ask you a question about your comments around the membership of the college council. The points you raised there are somewhat similar to some that were raised yesterday by the College of Physicians and Surgeons. In their proposal to us they suggested a 60-40 split. One of the questions that arose as well was about academic deans being involved in the council; I guess there is just one academic dean so it may not be the same issue with you. Could you elaborate on where we might find the perfect balance between one third and just under one half which you believe would provide the balance for self-regulation you are looking for?

Mr Krall: I am not sure I have that solution with me today. I am sure this committee will solve that. We merely wanted to point out our support for some point in between, and we think that is a reasonable compromise that would both protect the public yet leave our profession as a self-regulated profession. I still believe that if it is a true profession and we are self-regulated, things will be done correctly. If they are not, the government has certainly got regulations to make sure they will be taken care of in the future.

Mr Sands: Just to add to that, the colleges are different. Just to point out to the members, if the academic is the mechanism by which the government is looking at possibly addressing the membership issue, for some like medicine I believe it would be around five, but for us it would be more. It is still, as far as the college is concerned, not workable.

Mr Owens: I would like to thank Mr Sands for coming all the way from Scarborough Centre to make his presentation to us this morning.

I have a question with respect to your comments on the hospital exemption. How would you see the exemptions working, understanding that there may be a need for some exemptions out there? How would your association approach making those exemptions?

Mr Krall: At present, all hospital pharmacists are exempted. One of the discussions that took place was: "Include everyone. We realize there are going to be some areas of the province, some locales that have a difficult time obtaining the services of a pharmacist, but rather than giving the entire province a blanket, let's exempt those areas that perhaps have a problem, but let's not just leave the problem there. Why don't we work together to try to solve those problems?"

Mr Owens: Would you have any recommendations you could make to this committee or the interim advisory council?

Mr Krall: At the moment my recommendation would be that we sit down and try to work out a solution. I did not bring a brief with me on how to solve that problem, but I can assure you that, with the public good involved, the Ontario Pharmacists' Association would look to see what it could do to help.

Mr Johnson: Following Mr Owens's questioning, just how widespread is this concern you have about the hospital exemption? Are most hospitals staffed by pharmacists, or could you give me some numbers? I know that often in smaller centres they are like a dispensary more than an actual pharmacy, but certainly in larger centres I would imagine they would be equivalent to a full-blown pharmacy. I was wondering if you could give me some numbers.

Mr Krall: To be frank, I do not have those numbers. They are certainly obtainable, probably through the college, to determine how many hospitals do have licensed pharmacists on board.

Mr Johnson: I asked because I was wondering what you are basing your concern on. I know that if there were an exemption under the Health Disciplines Act, then this will continue under the new regulations.

Mr Krall: We expressed that concern in the past; this is not a new concern. Speaking frankly to the committee, the concern is really for the public. Pharmacists are already there, already serving the public in all these institutions. The pharmacists who are working there are asking also to fall under the regulations. I see it as a win-win situation to have them included. It protects the public. It makes the profession more responsible. I see it as a total win situation.

Mr Sands: Just to add to it, Mr Johnson, you might want to ask Mr Schwartz about it when he is before the committee. We did discuss it with Mr Schwartz. For some reason it was not addressed in the report, I believe. I understand that the rationale for not dealing with it is financial concern on the part of some hospitals. We believe the financial concerns are not that significant in terms of the overall considerations, and when you weigh those concerns against the public interest of having all pharmacists covered under the act, we come to the side of the public.

Ms Haeck: I want to address the issue of the title "doctor." Definitely my own concern is that there is a certain amount of confusion in a hospital setting. When you are talking about using "doctor," do you mean at the pharmacy or in a hospital setting?

Mr Krall: The title we are looking for is the PharmD. In Ontario at present almost all of these people are working in hospitals, and the vast majority of them are working in hospitals in Toronto. It is possible that some of these people could possibly work in the community; it is a possibility. Their degree would say "doctor of pharmacy."

The Chair: I have an appeal from Mr Hope for a short supplementary.

Mr Hope: To follow up on Mr Beer's comments, you said the just under 50% poses a serious threat. By my recollection from dealing with this, as long as you have 51% you still hold the dominant vote on these councils. That is why I do not understand where you say it poses a threat. As long as you have the majority vote on the decision process, where is the threat?

Mr Krall: I guess the word "threat" is a pretty strong one. The significant word is probably "self-regulated." With some of the material and experience we have had to deal with, I think the word "threat" is probably a strong one. But in the public interest, balanced with the self-regulated principle, I think somewhat less than that would probably be beneficial to both parties.

The Chair: Thank you for your presentation before the committee this morning. We appreciate your taking the opportunity to appear before us. We know you are aware that if there is additional information you would like to share with us, you can do so at any time in writing, addressed to our clerk.

1000

ALGOMA HOME CARE PROGRAM

The Chair: I call next the Algoma Home Care Program. Welcome. We are very happy to see you this morning. You have 20 minutes for your presentation.

Ms Hamilton: My name is Anna Hamilton. I am the administrator of the Algoma Home Care Program. I thank the committee for this opportunity to make this presentation, and my brief will be brief.

I am concerned with Bill 43, subparagraphs 26(2)6iv and vi, and also paragraph 26(2)5. They refer to catheterization; the next deals with bowel routines, going past the anal verge; and the third is injections.

I would like to outline three specific situations, because I am not sure how else to describe the problems that arise from this. Unfortunately, the legislation with those controlled acts lumps people with stable medical conditions in with people with unstable medical conditions who may require those treatments. That can create real problems in the community.

The three situations I would like to describe are a child with spina bifida in grade 1, a quadriplegic living alone, and an elderly person who is insulin-dependent who is also living alone.

The child with spina bifida in grade 1: Children with spina bifida usually require catheterization in order to empty their bladders. Catheterization requires passing an instrument "beyond the opening of the urethra." As children mature, they usually develop the muscular and hand-eye co-ordination to do this independently. However, until their skill is developed, someone else has to do this for them. When they enter school for a full day, this procedure must be done at least twice during the school day. Even for the kids going into kindergarten a half-day, it usually has to be done at least once from the time they leave home until the time they get back, depending on the circumstance.

The child in question is being taken by bus to school, so is unable to return home during the school day. Both parents work outside the home and are unavailable to go to the school to provide care for the child. The child does not usually have the necessary skills at this age to do the treatment independently. Under the legislation as it is presently being discussed, the only solution to the problem would be to have a registered nurse available when the child needed the help.

This immediately brings up several problems. The major one is that it results in a focus on illness because a nurse is required. This focus interferes with both the child and those in the child's immediate environment learning to accept the "child with a chronic condition" rather than "a chronically ill child." While the words in the two expressions sound very similar, in fact, from a philosophical and an attitudinal approach, they are almost diametrically opposed. In the first instance, the child is seen as a child, as an individual, and is not being defined by the child's medical problem.

A second problem is that having someone come in from outside the child's school environment is intrusive and disruptive. It is not the best way of meeting the needs. Even with the best effort to time a visit, there is little guarantee the visits will consistently happen when the child needs the visit and when the school schedule can best accommodate the visit. The care must be given when the nurse arrives, even if it means the child has to be withdrawn from a classroom while a class is in session. When this occurs, attention is immediately drawn to the child and emphasizes to the child and to the others that the child is different. The main advantage of using an individual who is already present in the child's school environment is that the care is available as soon as the child needs the care and the care simply becomes a part of the child's everyday environment; it is a task which must be done. It de-emphasizes the whole thing and basically does not permit the child to start manipulating around the whole fact that he has this problem.

A third problem is recruitment of nurses to provide these services when and where the child requires them. Algoma is no different from other areas in Ontario when it comes to having schools in sparsely populated areas. For example, the Montreal River School is approximately one hour north of Sault Ste Marie. If a child requiring catheterization were to enrol in that school this September, there is no source of nursing service for that child at this time. Even if a nurse lives in the area, there is no one on that nurse to provide service for that child. They may not

choose to do that type of work. Given no available professionals, must the parents move to an area where the service is available? Or should the child not be allowed to attend the closest neighbourhood school and be forced to take a bus to the school in an area where the service is available? Neither of these solutions are acceptable if there is a true commitment on the part of the system to integrate these children into their own neighbourhoods.

All these comments I have made pertain to children with stable medical conditions. For these children, it is my strong belief that if a parent can be taught to provide such treatment, then an attendant or aide can also be taught to care safely and effectively for the child. However, the safeguards that must be built in are adequate training for the care giver, adequate and ongoing supervision by a health care professional, and adequate updating—that is, in service—if the child's needs change.

The other situation is a quadriplegic living alone. This is happening more and more. We have got to the stage where we are actually freeing these people to go out and live their lives and make their own decisions and take care of themselves.

If, for example, the individual was on a bowel routine that included the use of enemas or suppositories, this legislation would prevent that person from hiring someone other than a nurse to carry out this particular function. If the individual were male, he may prefer a male attendant for all such personal care and be unable to find someone in his immediate area to meet his needs, because male nurses are not all over the place out there, while there is a larger pool of individuals to choose from if the criterion of "nurse" is taken off and you are simply looking for a male.

This legislation will again create more barriers for disabled persons in the area of personal care and will take some of their control back from them. This is a step backwards in time.

If what control the disabled have gained is not to be forfeit, then the health care system must face staggering increases in costs to meet their needs. There, I simply mean that if we are saying it must be a nurse, then the health care system had better come up with a nurse to provide the care when the person needs it.

The elderly person who is insulin-dependent: Many of these people do very well doing their own injections. As time progresses, they may become less able to do it. For varying reasons, the individual could no longer do her own injections. Her neighbour in the seniors' apartment building was willing to learn how to do the injections to help her friend out. This legislation would preclude such help from the informal care-giving network unless the person needing care lived in the same household with the person giving care.

What seems to be missing from the act is a definition of what constitutes a person's household. From a community health care perspective, this creates real problems. Does the same roof overhead define it? Does some relationship established by law or by blood define it? Can the daughter-in-law of an individual who lives in a different part of town come in daily and give the insulin? If the requirements of the legislation result in a nurse being the only

answer, a problem arises when the individual lives in a relatively remote community with no availability of daily nursing visits. Again, I am talking about simply finding the bodies to do the work that seems to be needed. Should the individual be forced to move to where service which meets the demands of the legislation is available to him or her?

Those are the three situations, and I would suggest that in none of them would having legislation that requires it to be a nurse giving the care be in the best interest of the individual. Free choice of place of residence may be restricted if necessary health professionals are not available as needed or if the health professionals living in the neighbourhood did not want to do that type of work, and health professionals, regardless of where they live, also have the right to choose to work or not to work and choose what type of work they wish to do.

That is the end of the written brief. Basically, I would suggest that I think, because we are talking about stable situations, the legislation needs to be looked at very carefully so we are not running into situations where we are being inappropriate in the type of care or level of care giver we are asking to provide this care. I would be happy to respond to any questions.

The Chair: Thank you for your very thoughtful presentation. I am going to ask the clerk to give you a copy of the Hansard which addressed the concerns you have raised regarding disabled persons and personal care. It is on the record, but Mr Wessinger is going to respond at this time as well.

Mr Wessinger: I would also like to thank you for your very thoughtful presentation, and I would like to assure you that the minister and previous ministers have indicated that there would be an exemption for attendant care givers by regulation under the legislation. That commitment is there, and certainly the committee is very much aware of the need to have that exemption.

I wish to ask you a particular question. You indicated you want certain safeguards with respect to the provision of care for children. I wonder if you might elaborate on that, when you say there should be ongoing supervision by health care professionals. First, I ask what you envisage by that and, second, do you envisage this with respect to children only and not to adults?

1010

Ms Hamilton: I would suggest that any health care professional, specifically in nursing, who is going in and teaching someone how to do something is not going to simply say the individual can do it and back out of the situation unless she feels comfortable with the level of understanding of the individual and ability to give the care properly.

I would suggest if I am dealing with children, in many instances, and again I emphasize that I am talking about children with stable medical problems to a large extent, the responsibility for flagging changes in the child's conditions lands with the parents anyway, and the parents supposedly have contacts with physicians or whatever. When it comes to a child in a stable condition, you are not going to have a situation where somebody wandering in once a month and looking at the child is going to pick anything

up. As for a child in an unstable condition, then I would not want to be talking about this anyhow when we are talking about attendants. I think I danced around the point.

Mr Hope: Good politician.

Ms Hamilton: I would suggest that in any situation, if someone is going in teaching, there should be some sort of care plan or description of what is being taught to that individual. It should be documented by the health care professional that, "I went in and taught that." If that is available, then there should be some safeguard in there.

Mr Beer: I would like to ask which date of Hansard was provided to the witness. Is that yesterday's?

The Chair: No, the one from the first week when Ms Bohnen—

Mr Beer: All right.

The Chair: I will give you a copy of it.

Mr Beer: I think it would be useful as well if perhaps yesterday's Hansard—the reason I mention that is that there was a group of people concerned about this issue who got together with the Ministry of Community and Social Services, the Ontario Medical Association and others. They came up with a draft amendment to the legislation which I think would be of interest to you and your colleagues in looking at how they approach this. I know there is a provision for regulation, but I think that would be useful as well, particularly as we go forward with long-term care and so on; all of these programs are going to have a greater need for this.

I wanted to come back to the issue of supervision. What are the particular problems you see here? You mentioned the school, Montreal River, and so on. I imagine you are involved in some of the planning around how long-term care is going to be provided here in the long run. What are some of the particular training issues and problems you see, and how are you trying to approach them in the north?

Ms Hamilton: In isolated communities, to a large extent we depend very heavily on finding somebody to teach who is someone other than a registered nurse or a registered nursing assistant. Again, the issue becomes whether you can find somebody who can be trained and whether, once the training has happened, you feel comfortable with their ability to carry it out appropriately. The third issue is of someone in that system, that individual who is the focus of the care, being able to flag when things are changing, for example, when it is no longer stable, when something else needs to be done.

We have a real problem because of the socioeconomic situation, especially here in Algoma. People are leaving the district. Those people are taking, in most instances, their wives, who are the nurses, the whatever.

As far as that is concerned right now, a lot of the supervision for any of the stuff that is happening out in the smaller communities is happening from the centre, that is, we try to dance very lightly and keep our finger very closely on any situation that we feel has the potential of somebody in there being at risk and needing closer supervision. Does that answer what you are asking?

Mr Beer: Yes, you have a list.

Mr Martin: My question has mostly been answered by the parliamentary assistant. It was to try to make a connection between the issue we have heard about so far on a number of occasions over the month around attendant care.

You brought to me a further concern of attendant care to children, because the assurance of quality of care was an issue. With the adult the adult himself can assure that he is getting the quality of care he needs; with children there is another concern there, and you also bring a perspective from the north and the unavailability of professionals. Will an exemption from this legislation in any way enhance your ability to do what you do best?

Ms Hamilton: Yes, it will, simply because if the professionals are not available I have no answers as to how we provide these services, therefore we have to have some exemptions so we can train somebody. But that puts the onus back on our system again to make sure supervision happens and that somebody is flagging things when kids are at risk or whatever, if for some reason there is nobody else in the system to flag it. For example, if the parents or the care givers who are with the children on an ongoing basis are not able to flag it, then the formal system of which I am a part is going to have to have something in there so we can catch those as well. I do not see that as a big problem, because generally the parents are good. They are going to pick up most of those sorts of things. But certainly some type of exemption is going to be necessary in order for us to deal with the kids out there, as I say, unless we are going to force people all to move into a centre somewhere and say, "I'm sorry, you can't live in Wawa" or wherever.

The Chair: I make the observation that the last statement by the presenter should be noted by the Ontario Pharmacists' Association, which is still here. I think it gives you a practical example of, and a response to, your question on why the exemption is in the public interest. Mr Hope, a question.

Mr Hope: Charles hit on it first, but I think it is important that we have a perspective from rural Ontario on the concerns you put forward around the disabled. I notice you keep using the word "flag." You are not saying "diagnose" but "flag" people. That is appropriate. You are not looking for a profession. With the papers out on long-term care, multi-year plan, trying to deinstitutionalize things, it is important that we have the non-Metropolitan Toronto view of things. I think it is important that you either communicate with the clerk or the clerk makes sure you get a copy, because the input would be valid. I just wanted to make that comment because Charles beat me to the question.

The Chair: Thank you for the comment. We appreciate that, Mr Hope.

I am going to do something we have not done before at this committee, with the support of the members. Our research assistant has available and is able to read into the record the amendment that was proposed yesterday at our hearings. With the permission of committee members I will ask him to read it into the record for all to hear again today, as that issue was raised.

Today I would like to touch briefly on some of those issues, because I think they have been well presented in the past. More important at this time is to really try to clarify what the basic outcome of the legislation is, and separating this basic outcome from the assistive devices program policies surrounding the provision of hearing aids. Historically there have been difficulties, even among professions providing services, on making that differentiation, and we would really like to focus on that today.

The cost concerns and risk-of-harm concerns were presented to this committee in London by a colleague of mine named Brian Field. The cost concerns, specifically with relation to OHIP billing for audiology services, were clarified, and system inefficiencies perhaps identified that now allow physician reimbursement for the supervision of audiologists.

As indicated to the committee at that time, the association is optimistic that, as one of the outcomes of this legislation, inefficiency in the system can be reduced, and that perhaps alternative funding mechanisms outside of traditional fee-for-service mechanisms be instituted that will allow funding for audiologists, not only in institutions but, most important, in community-based settings. That will be important particularly in the north, as I will allude to a little later.

The risk-of-harm criteria through instances of misdiagnosis, overamplification, particularly in the infant and child population, has also been identified to the committee. They have also heard a rationale that the prescription of a hearing aid is not a discrete act, that it is an outcome of assessment and diagnosis in taking into account a number of factors particular to each person. Again, those issues have been well clarified.

One issue I will deal with a little more specifically from a northern perspective is the issue concerning access to services. It is one that, having practised in the north for eight years now, I found of particular interest. I would just like to point out a couple of things to the committee concerning access. The picture that was painted back in 1988, when the assistive devices program was expanding to provide funding for adults and hearing aid services, was that access to these services by audiologists, particularly in non-metropolitan areas, was abysmal. There was really no good information available at that time to document one way or the other whether that was the case.

It was with great interest that we were finally able to get information through the assistive devices program, which was presented to a number of parties back in November 1990. Contrary to the description that was presented that audiologists are metropolitan-based creatures who do not venture into the north at all, and that alternative service providers in the form of non-audiologist authorizers are carrying the brunt of that service delivery, it was the exact opposite.

We saw a picture where, in the northern region, 72% of hearing aid authorizations were being conducted by audiologists. When we examined the non-audiologist authorizer profile, we found that almost three quarters of those authorizations were occurring in metropolitan areas. The reality of the situation seemed to be almost the reverse to what had been described.

One thing that was particularly perplexing to me was that despite apparent distribution of manpower and where services were provided, there was still an attempt on behalf of those service providers who are focused in metropolitan areas to suggest the most appropriate way to deal now with service shortages in rural areas—perplexed, and perhaps, having dealt with that similar situation in management positions and so forth over the last seven or eight years, a little annoyed at times.

1030

Service delivery in rural areas, particularly the north, faces very unique circumstances. We realize in the majority of health care fields that it will take special incentives to try to deal with those difficulties. What has been put forth as an option to address accessibility concerns is the distribution of non-audiologist personnel to provide authorizations for hearing aids.

That has been put forth as a cost-effective method as well. I cannot tell you how strongly I object to that from a functional standpoint. I have grave difficulties with the rationale that it is cost-effective. In a health care system that is overburdened, I fail to see the rationale of how training a one-dimensional professional and putting him in a rural setting, where the demands are multidimensional, will result in cost savings.

In satellite clinics that have been set up through the underserved areas program—and Elinor is well aware of those in Manitoulin Island, in Elliot Lake, to which I continue to provide service along with other audiologists—the vast majority of the work done is assessment work. Authorizing hearing aids is a small portion of the work that is done. What makes it cost-effective to provide those services in those areas is the fact that you can combine the two. And in those instances, you can provide a professional who is going to be able to assess children, infants, multiple-handicapped individuals, and is not going to be restricted to the provision of services to strictly adults.

On that rationale, I always have difficulty with the justification of pointing to rural areas and saying here is the way to solve the manpower needs up there, utilizing personnel that are concentrated in and provide services in the metropolitan area, and do so effectively in those areas.

When I hear myself talking that way, though, the other thing that strikes me is that those concerns regarding access and cost become very tangential to what the intent of the legislation is. I would ask the committee to really focus on what the basic intent of that authorized act is and what the basic functional outcome is, and to separate that from ADP policy.

Very clearly, that prescribed act does no more than ensure that a hearing-impaired person, whether that person is eight months old, eight years old, 98 years old, whether that person has other physical disabilities or is a so-called standard case to deal with, will be seen by a physician or an audiologist in the province of Ontario. It does no more than that.

ADP policy comes into play and will determine who can authorize some of these devices. But that legislation does not prohibit any service delivery model from existing under ADP policy. All it does is entrench what I think is a very substantial hearing health care goal in ensuring that a hearing-impaired individual is seen by a physician or audiologist. It provides a very comprehensive health care umbrella under which a funding program can operate without its hands tied. It can look at alternative service delivery models, alternative personnel, if it so desires and if through the advisory committee, through that program, there is sufficient information to justify looking that way. That program also has to take into account regulating the

I would like to go back to where you were outlining the results of the survey you did, because that really is an interesting result. You are based in Sudbury. How do you handle the outlying areas in terms of seeing patients and providing hearing devices and so on? How does that work for somebody who is in that outlying area?

Mr Shaw: That was a program that was developed initially, as I said, under the underserved areas program. What it is focused on now are two communities in particular, Elliot Lake and Manitoulin Island. Elliot Lake is serviced approximately eight to nine days each month. I or another audiologist visit that community not only to provide dispensing services or repair services and the like, but also, as I was saying, the vast majority of time is still spent doing assessment work and counselling work and the like. There is a similar program on Manitoulin Island. I believe it is usually five or six days a month that we are down there providing similar services. The service is comprehensive in that it is a one-stop shopping service. That is one model of service that is available, and in this particular instance it is effective. That is the way the devices are provided, with repairs and follow-ups along a similar line.

1040

Mr Owens: A question around access: You referred to diametrically opposing views. I share your annoyance, actually, at trying to get at what could be called the truth. My question is, where does the buck stop? Where do we draw the line?

Mr Shaw: On access, it is basically with a couple of things: in data that were verifiable on where people are getting services—data were finally made available to us in October and November of last year, once the assistive devices program had been able to gather specifics from when your program was expanded. I think the picture outlined was as objective a picture as you are going to get. There is always confusion that arises because the authorizing of a hearing aid has been intermingled with what happens to get service for a hearing aid. The two are not related. The authorizing of a device has nothing to do with the follow-up servicing and so forth. Those services can still be provided in exactly the same fashion as they have been in the past. Where I think the confusion arises is in not being able to separate out some of those access concerns.

In all fairness, there are areas of the province that are underserved and there probably always will be. It will be very incumbent upon the assistive devices program particularly and the advisory committee to that program to examine those areas and say, "How are we going to manpower-plan for those areas, utilizing audiologists"—and of course my preference would be that—"or other allied health personnel if necessary?" I think there is a good mechanism now in place for that. The current legislation does nothing to address immediate access. It gives us a full generation to manpower-plan by tracking that manpower now through the programming.

The Chair: Thank you very much once again for an excellent presentation.

ONTARIO NURSES' ASSOCIATION, LOCAL 46

The Chair: I would like to welcome the Ontario Nurses' Association, Local 46. You have 20 minutes for your presentation. I appreciate your being patient.

Mrs Olsen: May I introduce Karen Scott, a nurse practitioner from the Group Health Centre, and Elaine Craig, a home care co-ordinator.

Madam Chairman and members of the standing committee on social development, my name is Suzanne Olsen. I am a registered nurse, a member of the legislative committee of the Ontario Nurses' Association, and a staff nurse in the emergency department of the General Hospital in Sault Ste Marie. With me today are nurses employed by the Group Health Centre, Plummer Hospital, home care and the General Hospital in Sault Ste Marie.

Thank you for allowing me to present some major concerns we have as direct care givers concerning these three pieces of legislation, the Regulated Health Professions Act, the Nursing Act and the Midwifery Act. I understand that many health professionals, including nurses, have been part of a lengthy process of putting these pieces of legislation together. We applaud you for the intent of this legislation to protect the public from unqualified, incompetent and unfit health care providers.

After meeting with many staff nurses in this community, the general consensus is that there is much disappointment with this legislation as it pertains to nurses and their ability to practise safely and efficiently. This government has in the past been very supportive of nursing and its expanded role in the health care system. However, it appears to us that this legislation sets nurses back to a very subservient role.

We, as nurses in a northern community, do not have access to residents or supportive 24-hour physician staff and therefore have to rely on our educated decisions, which in the past have been backed up with supportive physician orders. But never before has there been the threat of a \$25,000 fine or a six-month jail term that impedes our right to protect the patient's health by our decisions.

As you are aware, standing orders and protocols do not have the legal authority of written orders. They change constantly, and doctors often write orders for us after we have done the work. This works efficiently for patient safety, but not for our own. It is an entirely unsatisfactory way in which we have to work. Every day we are at risk of being reported to the college for exceeding our authority. How then do you expect us to continue to act in the best interests of the critically ill patient if you are putting us in the position of being faced with being imprisoned or fined for doing what is prudent for cautious patient care?

We as nurses working in the north are not given the benefit of 24-hour physician presence, so therefore we are expected to act quickly to intervene in life-threatening health situations. We have always placed patient safety first, but we now have to rethink our direction, as you put us in a very quasi-legal position in which to practise.

We are accountable to the College of Nurses of Ontario as professionals and we are also accountable to our employers as employees. Management nurses in our legislation should be fully accountable to the college and this should

be explicitly stated in the Nursing Act. As you must be aware, there are cases where the courts have found that the college's jurisdiction extends only to nurses who perform hands-on care. We believe that if management nurses were accountable to the college for their policies and staffing, they would have to be much more realistic in their approach and this would reduce our double-jeopardy situation dramatically and would result in better protection for the patient.

I would now like to address the controlled acts. One of the areas of concern to myself and other staff nurses is the use of the phrase "on the order of a qualified person" which appears in two of the authorized acts for nursing. Restricting the activities of nurses by requiring an order for all controlled acts is detrimental to the public in that it will not coincide with efficient and safe patient care. If, however, these acts are to be restricted to qualified persons, I would hope that this group of persons would be as large as possible.

From my understanding, as it stands now some nurses, prescribed persons, will be allowed to write their own orders for two controlled acts: (1) performing a prescribed procedure below the dermis or mucous membrane and (2) putting an instrument, hand or finger beyond certain points of the body. These nurses will be selected by the council of the College of Nurses of Ontario, and I would suggest that it would greatly improve patient care if this group of prescribed persons were made as large as possible.

Controlled act 1, "communicating to the individual or his or her personal representative a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the conclusion": This is not a controlled act listed for nurses and thus creates great concern among nurses. If it is not a controlled act for nurses, how will we continue to act in our present capacity as health teachers? On a daily basis we answer questions posed to us by patients who are under a great deal of stress, given the fact that they are anxious concerning their disease. If we are unable to discuss their illness, how will we obtain consents for surgery and continue with nursing diagnosis?

As you know, nursing diagnosis is a practice that is widely accepted all over North America. Many consents for surgery are obtained by nurses after initial examination by a physician and before sedation. This will not be allowed under the new legislation, as nurses will no longer be able to discuss medical diagnosis with patients. Because consents are not legal after the sedation, these same patients will have to remain in pain until the surgeon explains their diagnosis and ensuing procedure to them. Because of the time element, a great deal of time this happens immediately before surgery, and we as nurses do not find this acceptable.

Staff nurses spend a great deal of time giving patients pre-op teaching, prenatal care and discharge and home care planning. How then can we continue to discuss any matters concerning their diagnosis? Nurses spend 24 hours a day with their patients; physicians spend minutes per day with their patients. How then can we protect their rights? A fast explanation of a disease by a physician leads to many

questions, to which we as care givers feel the public has a right to answers.

On many occasions receiving health information in a timely manner is imperative for the maintenance of the health and life of our patients. We as nurses do not conceivably feel that we should determine the medical diagnosis, but we would be wrong, however, to deny that we must have the right to draw conclusions using nursing diagnosis and to feel free to answer our patients' reasonable questions. Therefore, the communication of a dysfunction needs to be a controlled act for nurses, or you, ladies and gentlemen, will be tying our hands and driving more of us away from our profession.

When I first entered nursing in the late 1960s, it was unheard of to answer any patient questions relating to disease. We have come a long way in 20 years. We have maintained our confidence through continuing education and we have accepted the role of patient advocate, but without this as a controlled act for nurses, we will be forced to be quiet once more. May I stress that I do not feel that this is the intent of your legislation. Please do not ignore our skills and experience by denying us the right to do more controlled acts independently.

Controlled act 5, "administering a substance by injection or inhalation": This is a controlled act listed for nurses, but on the order of a qualified person. The amendment to this controlled act in the Nursing Act, paragraph 4(1)2 changed "on the order of a qualified person" to "on the order of a member of the College of Physicians and Surgeons of Ontario." This will create great problems for nurse practitioners working at an advanced level in this community. I strongly question the reason for amending this section.

Controlled act 12, "managing labour or conducting the delivery of a baby": After discussion with many nurses, I have been asked to emphasize just how important it is to include managing labour as a controlled act for nursing. We as nurses do not oppose midwifery, but we do feel that midwives must be nurses, especially if they are employed in a labour area that is managing difficult labours. The scope of practice of midwives overlaps the scope of practice of nursing. It is not logical to feel that there are enough trained midwives to take over every labour and delivery area in Ontario. How then will the obstetrical departments continue to function if this is not a controlled act for nurses?

Nurses currently employed and practising in these areas clearly manage labour, and in many cases in the north they deliver the babies when the physician does not arrive in a timely manner. Managing labour is included in the basic educational program for nursing. Managing labour envelopes below the dermis or mucous membrane or beyond body orifices and non-intrusive actions. Because intrusive interventions are regulated by other controlled acts, I assumed that managing labour would be the care, support and assessment of the mother and foetus and the recognition, prevention and intervention in a labour crisis. If this assumption is true, it would be very important for the safe care of the mother and foetus to include managing labour as an authorized act for nursing. May I suggest that nurses as well as midwives and physicians should be able

to manage labour. We in fact already do this and it overlaps the scope of practice, and this should be recognized.

1050

The specific recommendations I would make after consultation with my colleagues are:

1. That prescribed persons who will be selected by the council of the college of nurses be made as large a group as possible;

2. That nurse administrators, educators and researchers should be fully accountable to the College of Nurses of Ontario and this should be explicitly stated in the Nursing Act;

3. That the first controlled act must differentiate between medical and other types of diagnosis, medical diagnosis being limited to doctors, but nurses and other health professionals should be able to communicate their diagnosis to their patients; and,

4. That nurses, as well as midwives and doctors, should be able to manage labour.

In closing, I would urge you not to overlook the valuable source of human resources that you have existing in the nursing profession. Our aspiration for the health care system in Ontario is that it can remain one of the best health care systems available for the people of Ontario. We appreciate that costs are soaring. However, we feel that compromising the quality of health care is not acceptable and we are willing to do whatever is possible to ensure that the health care system remains as it is today. We hope to be considered as a valuable source of input into the future decisions that directly impact on patient care and safety.

The Chair: Thank you very much for your presentation. A comment first from the parliamentary assistant, Mr Wessinger.

Mr Wessinger: Thank you for your thoughtful presentation, but I would like to indicate that certainly in our opinion there is nothing in the legislation that prevents you from discussing a diagnosis with a patient. I would also like to indicate that the whole question of assessment is not covered as a controlled act, and also the communication and discussion of assessment, again, is permitted to you as health professionals. It is not a controlled act.

I also would like to indicate with respect to the question of managing labour that we understand that is dealt with as a delegated act, so I understand you would be able to continue to do that as a delegated act.

Mr Beer: I have a couple of questions, one in terms of the managing of labour. I ask the parliamentary assistant—and I would appreciate your thoughts on that—what the reason was for having that as a delegated act as opposed to its being in the act itself. What is the rationale for that?

Mr Wessinger: I will refer that to the ministry staff.

Mr Burrows: It is unfortunate that legal counsel is not here today. My understanding is simply that there are valid reasons. I wonder if it would be possible to raise that question with legal counsel on September 16.

Mr Beer: I will do that. We will follow up on that one and see if we can get a clearer answer.

The question around the nurse administrators, the educators and the researchers has come up in a number of the presentations. What you see is that because they are in

effect managing what you do, they should carry the same responsibility you would have to carry before the college if there was any disciplinary measure. What is their status right now?

Mrs Olsen: As far as I understand, in cases they have not been held accountable; it has been the individual nurse. We are placed in a position, through staffing for instance, that if an administrator or a nurse-manager, who is part of middle management, decides, when we ask for help, say, in the emergency department because of an extra workload, that it is not necessary and something happens on that particular shift that endangers the life of somebody, then we are actually accountable as professionals before the college but he or she is not held with the same responsibility.

Mr Beer: Would you agree that if they were covered by the law that there could be instances where both of you might be held accountable?

Mrs Olsen: Absolutely.

Mr Beer: You just want to see that they are there as well.

Mr Martin: Because I am from Sault Ste Marie, I just wanted to say that I have had the privilege of having a nurse practitioner look at me, and also in the delivery room. However, my question is around the non-inclusion of nurse-managers in the college. I do not understand that. Maybe you could expand on that a little more for me, how that would impact on your ability to operate as a nurse.

Mrs Olsen: As a nurse, I am accountable to the college for the things I do in my everyday practice, but managers are not doing direct patient care. They are providing the service only in that they are staffing their particular departments. They are not there 24 hours a day; they are there only from 8 to 4. We are practising 24 hours a day and we do not have the same resource on certain shifts.

It just seems that if they leave us in a position where our practice can get into trouble, they are not as accountable as we are. We are there doing the work. They are at home, not worrying that we are understaffed, that we are trying to take care of four different things where we should be doing only one.

If they were accountable for staffing, they would have to have the proper number of people to care for the patients, whereas they can kind of wash their hands of it and say, "Cope." That is something we hear an awful lot, "Just cope; we know you can handle it." Sometimes that puts people in jeopardy. That puts people in a position where they are not going to get proper care.

Mr J. Wilson: I very much appreciated the brief. It was a very good job of articulating the views. We have heard some of them before. I am particularly interested in your comment that this government has a good track record with nurses. I would simply comment that they have zero track record with nurses. They have not been the government long enough to have a track record, but perhaps you are referring to their statements in opposition. They are now discovering that being a government is not as easy it looks. But I will ask a question.

Mr Hope: It is about time.

Mr J. Wilson: Well, these things keep creeping into these briefs and I cannot understand it. Having said that, perhaps you can give us a better feel of what a nursing diagnosis is versus a medical diagnosis.

Mrs Olsen: We use all sorts of tools to determine nursing diagnosis. We have assessment forms we fill out. When someone is admitted to the hospital, we have a two-page form that asks various health questions that physicians would probably ask in their initial assessment, but they seem to refer to our nursing diagnosis to determine some of the symptoms of their patients, after the fact. They depend on us to spend a lot more time with these people, questioning them on their health habits, on what they do to prevent disease. They do not have the time. A lot of times their physical assessment is very different from what our nursing assessment is. Then we discuss together why they made a certain medical diagnosis versus why we feel there are other things that might be bothering this person.

1100

Mr J. Wilson: Has the association sought a legal opinion on whether it would be prohibited to bring a number of things under the scope of nursing diagnosis because of the controlled acts?

Mrs Olsen: I believe they have done some looking into some things legally, but I cannot hope to answer for the association. I am only a nurse. I am concerned as a staff nurse. I do represent, partially, the Ontario Nurses' Association, but my scope of practice is not directed by them. I am responsible for myself as a professional and to my patients—most of all to the protection of the patients in the north.

We do not deal, in the north, with southern Ontario medicine, where you have people around all the time. I work in a very busy emergency department. In this city, we have one doctor on call for 15 physicians, between two hospitals, for 75% of the day. They are not there when people walk through the door having a heart attack. They depend on us to start all sorts of things. We start the IVs. We order the blood work. We have everything done by the time they come. We stick them on the monitor and realize before they have even arrived that they are in a lot of trouble.

We have always done that. I am not saying we have even protocols that say, yes, we can do an invasive action like starting an IV, but we do it and we get coverage from these physicians. But when you are threatening us with being fined and imprisoned, we are not going to feel quite as safe working on our diagnosis.

As an emergency nurse who has worked for 20 years, I can look at a monitor and know that somebody is infarcting. I do not have to wait until the physician walks through the door and says: "Start everything. Do the blood work. Do the ECG." I do that and I do that because I care for the person who is lying there on the table. Time is of the essence. We do not have a doctor there all the time.

Personally, I will probably continue in the same practice, but it is going to make me a little bit nervous if I think I can be reported for overstepping my authority, because really I do not have authority to start all those invasive actions.

But we have been doing it for years, and it is necessary for the safety of the patients up here.

The Chair: I have a very short supplementary to the statement you just made. Are you saying that in your hospital there is no hospital protocol for managing of emergency procedures?

Mrs Olsen: You can say "protocol for managing emergency procedures." There is a blanket protocol. A nurse on the IV team can institute an intravenous, but we do not have standing orders from every physician. We have standing orders from cardiologists, but now that the general hospital does not have a cardiology department, those standing orders are quasi-legal. They are legal in that if you work in a cardiac unit you can start all this stuff. We get blanket orders, but we really do not have anything that says: "Yes, Suzanne, you can take the blood work. You can do the cardiac workup." We get it covered. We have never had any trouble with the physicians saying, "You shouldn't have done it."

Well, no, I should not say that. We have had trouble with physicians saying: "What do you think you're doing? I didn't order that." We just basically ignore them and say, "This is our protocol." They do not fight us on it.

But we have never been threatened before with being fined for doing this stuff. We have physicians who come from southern Ontario who cannot believe all the things we do, but we have done it because there is a need there, because there is not somebody there to say, "Do it."

Mr Owens: I want to follow up on my colleague's question with respect to nurse practitioners. I wish you folks had been a little more detailed on exactly what impact this legislation may have on nurse practitioners. As Sault Ste Marie is a relatively more urban centre, again relative to Beardmore or Pickle Lake, how do you perceive this legislation impacting on what nurse practitioners are able to do?

Mrs Scott: I can answer that. Nurse practitioners in Sault Ste Marie basically are doing physicians' jobs. We have-booked patients. We diagnose. We treat. All of these orders are countersigned following the fact, not pre-empted. We have a protocol on things we can and cannot do, but all of our delegated acts are countersigned afterwards.

We feel this legislation has not opened up to allow us to do the things we are doing, and that we should be part of that delegated act. You are allowing it for midwives but you have totally ignored the nurses. People are looking for a different type of health care. I hear it every day in my practice: "You listen to me. You hear what I am saying." With this act, you are going to take that away from them.

The Chair: Thank you for an excellent presentation. I know you have answered some questions for the committee that have been lingering. Today is the last day of our hearings and we really appreciate hearing from you. I would remind you and all other presenters that there is an opportunity to communicate further with the committee in writing during the course of our deliberations if you feel there is any additional information that would be helpful to us. Thank you again.

FAMILY SERVICES CENTRE

The Chair: I would like to call next the Family Services Centre. You have 20 minutes for your presentation.

Mr Rivard: My name is David Rivard, executive director of the Family Services Centre. I may not take the whole 20 minutes allotted. I was listening to the previous presenter, who identified herself only as a nurse. I guess I identify myself only as a social worker.

As a preamble, part of the concern you may have come across in other communities is the fact that social work has not been included as a part of Bill 43, and certainly that is initially a problem that the social work profession sees as a major difficulty. Particularly within many of the health settings, social workers play a most significant part in the whole health care team, as do nurses and other professionals. Undoubtedly, without any kind of legislation to protect the practice of social work, individuals who work in our employ are placed in much jeopardy. I will basically use that as a preamble and get into some of the key things I wanted to mention.

Who are we as an organization? We are not necessarily considered a health care service, but if you look at the definition of health care, it would in fact, in my mind, include agencies that are providing what we will call mental health services. Locally, the family service agency is a non-profit social service organization committed to strengthening and enhancing family life, and a large number of the programs that we provide fall into that category of mental health. Some of the programs we provide are funded directly by and under the auspices of the Ministry of Health.

Some of the client population groups we deal with, as well, are individuals who have been through the health care system, most notably those who are survivors of abuse, particularly sexual abuse and wife abuse. In fact, when you look at the research involved with that, approximately 80% of these individuals have had contact with a physician prior to coming to a social service agency. Part of the difficulty has been the improper diagnosis of these individuals and giving them a psychiatric diagnosis when that was not necessarily the issue they were dealing with. So we see many of these people who have been through medical, psychiatric settings and are now showing up within social service organizations and who have been improperly diagnosed. In fact, 80% of the client group we deal with currently falls into this category of being survivors or victims of domestic violence and sexual abuse.

The other major category we deal with are those, particularly youth, who are struggling with problems around drugs and alcohol. Again, many of these young people, as you know, unfortunately end up going into the American system and often getting diagnosed and so on and spending large sums of money. Again, we would want to see more of that being put into our province.

Other groups are the developmentally handicapped adults, many of whom, as well, are deinstitutionalized and are now moving back to the community. They are suffering from a variety of problems and disorders, and we have a program that deals with really helping them to reintegrate to community life.

One of the final groups is what is called the stage 1 young offenders. These would be people 12 to 15 years of age who have been through the court system and are now what is called post-disposition. Our service would provide some counselling and support for them within the community.

The majority of staff employed by our organization would be deemed social workers: addiction counsellors, graduates of community college and university in child care, social sciences and a variety of other degrees. All of our staff are trained to complete what is called a psychosocial assessment, which really looks at the psychological and social, environmental makeup of the individual, and, as well, to conjointly share that assessment, or "diagnosis" if you wish, with the client directly. Again, there is that whole essence of being involved directly in reporting to the clients the nature of the problems they are experiencing. So that is a little something of who we are as an organization.

1110

What are some of the concerns we have? Certainly, up front we want to support the intent of Bill 43 and really see it as an excellent piece of legislation. However, one of the gravest errors was not to include a profession which has been struggling for years to be recognized by the legislators as a profession, and that is the profession of social work.

It is unfortunate that we are the only province now in Canada that has no particular legislation to protect the public from persons who will call themselves social workers who do not have any specific training and so on. In the absence of legislation, this leaves, in my mind, people in our employ who in essence can call themselves social workers in some amount of risk of being prosecuted.

We have as an organization supported the need for specific legislation. Mr Beer will know from his position in previous governments that it was supported, basically, to go ahead with a social work act. We would really encourage this committee to talk to the current government to say, yes, there is a need to proceed with legislation to protect the public. Whether that be a specific social work act or an omnibus social services act that would include a number of other quasi-professions, certainly it is important to move ahead with that.

As an organization, one of the clauses we would be specifically concerned about is the one that is referred to as the diagnosis clause. My concern in reading this particular clause is that it may hamper individuals within our organization from making what we call a psychosocial assessment or a specific diagnosis as to the nature of the difficulties the client is presenting to our organization, if that would prohibit our staff from completing their job functions.

In turn, one of your other subsections points specifically to the fact that employers and boards and so on, organizations that employ these unregulated practitioners, may in fact be in a position of possibly ending up in litigation.

Those are, from our perspective, some of the primary concerns, particularly around this whole issue of diagnosis: who is allowed to make a diagnosis and what kind of implications that will have on an organization that is currently employing staff who are not regulated.

What are the solutions? One of the primary solutions that would, I think, assist in the whole process is to proceed with a social services or social work act which will incorporate those professions currently not listed in Bill 43.

There is an employment base of approximately 10,000 professional social workers in Ontario, and a little over 25% of those social workers work directly in the health care setting. Again, under this present bill, there is no protection for these individuals who do actively participate on the health care team. In fact, many of them, as with nurses, are often the first individuals to share with a patient or client the whole nature of the diagnosis and the problems that the individual is dealing with. So I will be waiting to hear from you whether you feel the current bill expands or hampers the ability of these health care professionals to in fact deal directly with patients or clients.

The whole issue of the communication around the diagnosis or assessment—I am referring to point 2: Should this really, then, be inclusive to all other sections of the legislation, not just those involved in the controlled acts? I am aware that the Ontario Association of Professional Social Workers, in conjunction with the Ontario College of Certified Social Workers, made a presentation and also asked your committee to look at that option. If you are going to include this for certain segments, why not include it for all within the legislation?

When we look at definitions such as "disease," "disorder" and "dysfunction," again, I think those clearly have to be defined. Many of the health care practitioners, social workers in particular, tend to shy away from using terminology such as "disease." If you are going to use "disease," "disorder" and "dysfunction," I think it is only appropriate that those be clearly defined.

Fourth, until legislation can be brought forward to really regulate professions currently not included, every consideration must be given not to prevent organizations such as ours and other social service agencies from practising professions which are recognized—they may not be recognized in legislation, but are recognized locally and at the provincial and national levels—due to the fear of prosecution. Again, I know this is a concern that has been brought to your attention previously.

It is our hope as an organization that some of the issues we have discussed today, along with many of the issues brought forward by our colleagues across the province, will be listened to by your committee, and in any way if they can be adopted into legislation, we would appreciate that.

Mr Hope: Under your solutions to the problems, you indicate a social worker act. We have had presentations, both in support of a social worker act and against a social worker act. Dealing with this legislation we see a lot—

The Chair: The social work act is not before the committee at this time.

Mr Hope: I know, but it is part of his solution as a recommendation to the committee and point 1 of his brief. With the issue of diagnosis—I know you make reference to making it clear under "disease," "disorder" and "dysfunction"—would it be appropriate for "disease" and "disorder"

to be deleted under the social work part of it so that you can communicate?

Mr Rivard: Certainly, as I mentioned previously, social workers would shy away from using that type of terminology. Often, though, if you are working within a health care setting, you would have no choice but to communicate that to a client or a patient. Under this current bill, there is no opportunity for social work to participate. That is the grave error I was concerned about. If there is an opportunity to include that, I would recommend it. If not, there may have to be a decision to look at some other piece of legislation that would protect the public, because the whole intent of this legislation, from my reading, is the protection of the public.

Mr Beer: I would like to follow up on the terms "disease," "disorder" and "dysfunction." If the word "dysfunction" were taken out of paragraph 26(2)1, in terms of what social workers are doing would that alleviate the problems you see around that diagnosis clause? I appreciate the other question around the social work act, and that may come about, but certainly this is going to be dealt with first. But is that the term which for the social work practitioners is the biggest problem with this?

Mr Rivard: I would not say that is the only term, necessarily. I think the three terms together cause some difficulty for social workers. We think of "disease" as much more a medical terminology but, as well, I think you can broaden that to say a community can be diseased, if we look at our own community being economically affected. Again, whatever terminology you are going to use has to be clearly defined, because we all have our own interpretation.

Mr Solà: You said something in your preamble that disturbs me greatly, and I hope I heard wrong or misinterpreted what you said. I think you said that of your client group, 80% are misdiagnosed. I wonder if you would elaborate on that, because that is very disturbing to me.

Mr Rivard: From our own practical experience, with 80% of the client groups we are dealing with being victims or survivors of domestic abuse and sexual abuse, a large portion of these individuals have been into the health care system and have been given a psychiatric diagnosis which in retrospect may not necessarily have fit the condition that person was experiencing at the time. They may have been manifesting certain behaviours and a diagnosis was placed on that. Part of the difficulty now is that these people are coming forward and saying: "I was a victim of sexual abuse within my family of origin. I wasn't at the time able to talk about it, but that was the secret I was keeping within. I may have been manifesting certain behaviours and from that a diagnosis was made." The person may have been put into a psychiatric facility. A lot of these people are now coming out and saying, "I didn't really have psychiatric problems, but I was put into that particular institution, so maybe I was inappropriately diagnosed."

The Chair: Thank you very much for your clarification and your presentation. We appreciate your appearing before the committee today, and I know you are aware that you can continue to communicate with the committee in writing over the course of our deliberations.

Mr J. Wilson: Madam Chair, I have a request for information from the parliamentary assistant. I believe it is on September 16 or 17 that we are meeting with ministry officials. Could we add to that list, if we have not done so already, the Attorney General's office? I know there are officials over there who have given comment in the past on this legislation and we would like the opportunity to address some concerns with them.

The Chair: The request is noted.

1120

TOM HENDRIE

The Chair: I call next Tom Hendrie. You have 10 minutes for your presentation.

Mr Hendrie: Thank you, Madam Chair. As practising medical laboratory technologists working in the hospitals of Sault Ste Marie, we are pleased to have this opportunity to address this committee and we hope our comments will be helpful in the committee's consideration of Bill 43 and companion legislation, Bill 44 to Bill 64. We are specifically interested, of course, in Bill 53, related to medical laboratory technology.

Our interest in this legislation is heightened by the fact that one of us was chairperson of a special committee of the Ontario Society of Medical Technologists back in the early 1980s whose deliberations and representations enabled the OSMT to mount a successful lobby in the Ontario Legislature, which we felt was a contributing factor to the decision to conduct a Health Professions Legislation Review.

Ten years later we are on the verge of having appropriate legislation enacted, and as private citizens we maybe should be concerned that it has taken so long and that the legislative wheels turn so slowly. As professionals, however, we are confident that the necessary research and fact-gathering has been very thoroughly carried out and we have a piece of legislation which is acceptable to the professions concerned, which truly benefits the citizens of Ontario—although, from what I have heard in the last half-hour, we could go on talking about it for another 10 years.

Anyway, we are very pleased that we will soon be forming a college of medical laboratory technologists to set standards for the practice of our profession in Ontario, and will charge the profession with the responsibility of ensuring these standards are upheld. We are pleased that our leaders have been able to show the profession is ready for this responsibility and we wish to assure you that the rank and file medical laboratory technologists is ready, able and enthusiastically willing to assume this responsibility.

We feel that the legislation can only enhance Ontario's reputation as having one of the best health care systems anywhere. We feel this reputation is deserved and pray the standards can be maintained in spite of the present federal government's new approach to funding.

Concerned professions as represented by Interhealth were asked by Elinor Caplan—I did not realize when I wrote this that she was chairing this session today—that the legislation should move forward in spite of imperfections. A unanimous "aye" was given as answer to this question and everybody was very happy.

Now I would like to bring the committee's attention to some points which we see as imperfections and express the hope that they can be dealt with later.

1. The minister's proposed amendment recommending the inclusion of a controlled act permitting medical laboratory technologists to obtain the blood sample for testing with the addition of a subsection 3(1): "In the course of engaging in the practice of medical laboratory technology, a member is authorized, subject to restrictions on his or her certificate of registration, to take blood samples from veins or by skin pricking."

We feel it is strange that this is the only controlled act considered necessary for inclusion in this bill. It may be that the committee, mostly being lay people, feels that invasive procedures using needles were considered the only medical laboratory technology activity which was potentially hazardous to the laboratory services users, that is, the patients who come to us.

The legislators and the public need to know that there are dozens, perhaps even more, of acts performed exclusively by medical laboratory technologists which, if not done exactly right, can result in serious injury or death. The most obvious of these potentially hazardous procedures is perhaps testing and matching of blood for transfusion. This task is carried out exclusively by our profession and needs a thorough knowledge of blood transfusion theory and technique along with considerable dexterous skills, which often have to be called upon in highly stressful situations. There is no room for error, and serious error can result in what could arguably be called wrongful death.

Many other tests we do concern monitoring levels of drugs, ie, digoxin, when the attending physician needs to know the blood levels so he can prescribe dosage and avoid calamitous overdosing. The technologist performing those analyses has great responsibility, and mistakes can cause very severe harm to the patient.

I could go through a whole litany of these situations. As to listing them in the Medical Laboratory Technology Act, it could be argued that all of these tests should be designated as such.

We also have a concern, a lesser concern, I have to admit, about the practice of medical laboratory technology in unlicensed facilities, for example, in doctors' offices. Doctors' office testing, though presently limited, is exempted from control of the director of laboratory licensing by authority of regulation 845 under the Laboratory and Specimen Collection Centre Licensing Act of Ontario when performing certain simple tests. We feel that doctors should not delegate this testing to personnel who may not be regulated by the proposed new college under this legislation. We are not saying this kind of thing is happening at present, but we realize there is a potential. We would hope these concerns can be appropriately dealt with in the regulations under the act.

Thank you for this meeting. We look forward to a speedy implementation of the said acts and wish your committee success in its final deliberations and recommendations.

Ms Haeck: Thank you very much for providing us with a very interesting presentation. I do want to get some clarification at this point, through the parliamentary assistant,

some comments from ministry staff. Mr Hendrie does make mention of the Laboratory and Specimen Collection Centre Licensing Act. Are there certain of these procedures which the medical lab technologists would be performing that are controlled by other pieces of legislation, say something in a hospital setting? Particularly, why limit to just the blood collection? Are there criteria for inclusion that maybe those other acts did not meet under the whole process of looking at the Regulated Health Professions Act?

1130

Mr Burrows: Again, unfortunately legal counsel is not here; I am not an expert on the law. However, there are various controlled acts in this package that are controlled by other pieces of legislation; for example, X-ray under the Healing Arts Radiation Protection Act, and in the case of activities performed by many people in the institutional sector, other pieces of legislation, the Public Hospitals Act, and in this case Laboratory and Specimen Collection Centre Licensing Act.

With respect to the specific amendment put in by the minister for discussion, it was concluded that this act was not dealt with by other criteria being applied. The review, having as one of its criteria for selection whether or not other legislation did satisfactorily control the activity, and the ministry concluded that a specific situation with respect to the common drawing of blood by lab techs should be covered by a specific controlled act, so that was put in.

In the case of the others, the evidence presented to the review and the evidence presented to the ministry since by the provincial associations on behalf of technologists, did not convince of the need to mention the specific acts. Either they were controlled by other legislation, or they were done in a way, for example, that they were either uncommon and could be dealt with by delegation, or they were done commonly but they were done in the presence of another professional who was accountable, because the person was right there. There were various reasons such as that.

The Chair: Thank you for your presentation today. If there is additional information that you think would be helpful to the committee, please feel free to communicate with us in writing through our clerk.

Ms Haeck: Supplementary to my question, I wonder if we could be provided with a series of those acts, those other pieces of legislations that impact on the RHPA and some of those groups, and maybe some of the criteria as information for all.

The Chair: On the days of the 16th and 17th of September, through the ministry presentations, I think there will be a full presentation on which other pieces of legislation will require amendment as a result of this legislation.

Ms Haeck: Very good. I appreciate that.

JOYCE ISBITSKY

The Chair: I call next Joyce Isbitsky. You have 10 minutes for your presentation.

Dr Isbitsky: I will try to talk fast. I have written out my stuff because I get a little nervous. I am not used to talking in front of committees. I will read fast, and I will try to leave some time for questions.

Thank you for this opportunity to comment on the Regulated Health Professions Act and the Psychology Act.

My name is Dr Joyce Isbitsky. I am a registered psychologist in independent practice based in Sault Ste Marie. I am also the director of the midnorthern region of the OPA, the Ontario Psychological Association, and in that capacity I represent about 35 members in Sault Ste Marie, Sudbury and North Bay, as well as a number of smaller northern communities.

First, I support the position expressed in submissions by the OPA and OBEP, Ontario Board of Examiners in Psychology, and by my local colleagues earlier this morning. As you know, the primary concern relates to the removal of all restrictions on the terms "psychology" and "psychological."

Second, I believe the adoption of the recommendations offered by OPA and OBEP would allow the praiseworthy objectives of the legislation to be realized without compromising the needs of the north. As it stands, I fear the proposed legislation will retard rather than promote the north's continuing struggle to guarantee its residents standards of health care on a par with the rest of the province.

It is no secret that accessibility of professional services, health care and otherwise, is severely limited in northern communities. There is neither a sufficient number nor range of practitioners to enable the delivery of comprehensive services. The services we do have are often geographically inaccessible or tied up in long waiting lists. Psychological services are no exception, with no more than 2% of psychologists employed outside the large provincial centres in North Bay, Sudbury and Thunder Bay. It is extremely difficult to attract and retain qualified professionals because of professional isolation, lack of opportunities for professional development, inadequate program resources, and, let's face it, lousy weather.

Those involved in the delivery of psychological services who wish to become psychologists must leave the north in order to do so. Because of the scarcity of qualified practitioners, there is a tendency to make do here with unregulated persons unable to deliver the level or range of care available in more populated areas.

Recent conversations I have had with department heads reveal that in the north job requirements are often downgraded or watered down once it appears that advertised positions will otherwise remain vacant indefinitely. The scene is set for a proliferation of practitioners who have not met minimum standards of practice, conduct, education and training.

That, unhappily, is where it is at in the north.

It follows that northerners have to be especially vigilant if they are to counter the possibility of harm. In fact, the opposite is true. Many northerners are ill-equipped to make informed choices in seeking health care and other professional services. Why is this so?

Northerners, especially those in smaller and more remote communities, have little access to accurate information about available services. They are not likely to have had exposure to psychologists, or other regulated professionals for that matter, or to sources of good advice such as teaching hospital departments of psychology, university graduate programs in psychology, or regulatory and voluntary professional associations, such as OPA and OBEP.

Let me illustrate. A client employed by a government ministry was referred to me by her physician. The ministry employee assistance program manager advised me that other psychologists were already available to ministry employees on an immediate basis. She was misinformed. The so-called psychologists were actually unregulated crisis workers.

Another example: The director of a local health centre assured me that the centre employed a psychologist. Again, the individual in question was an unregulated provider. I think this addresses your question about the burden being on the employer. It may be on the employer, but it does not mean it is working. Again, the individual in question was an unregulated provider.

Why should we expect the average Joe Northerner—I hope nobody is named Joe—to be better informed than these individuals in key positions within the health care system who do not know what a psychologist is and is not?

In failing to limit the descriptors "psychology" and "psychological," the proposed legislation will just add to this confusion, thereby increasing the potential for harm. Restrictions on the use of professional titles and descriptors is one way to ensure that service providers are accurately identified.

Earlier, Deborah Brooks stressed the dire need for qualified and accountable practitioners in the schools, given the risk for serious and lasting harm to children. Presently, Sault Ste Marie has not a single psychologist in either the public or separate system. Efforts to attract regulated psychologists to northern school boards would be hampered if school personnel were free to represent themselves as providers of psychological services.

Finally, issues of supervision and training—we touched on this earlier—are critical in the north. Arranging supervision can be very complicated here because there are often long distances to travel and few psychologists to act as supervisors. Despite this, the efforts of psychologists and subdoctoral ancillary psychology personnel to make the system work are impressive, thereby ensuring uniform standards of practice across the province and lowering the potential for harm. As such, I applaud the recent tabling of a memorandum of agreement between OPA, OBEP and the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists, OACCP, which would seek provisions to recognize and regulate the many high-quality MA-level providers within the Regulated Health Professions Act.

Any questions?

Mr J. Wilson: Your colleagues this morning indicated they thought that the PhD issue and the MA issue were perhaps separate. I will give you a hint: Much of the thinking of the colleagues on this committee is that they are one issue, and a very important issue. It has been discussed for a number of years and we have finally seen a memorandum of understanding or agreement between the two parties.

We have had testimony, from I think some northerners who testified before us in another part of the province, saying there are a number of MA-level practitioners practising almost totally independently in parts of northern Ontario and that they seldom see a PhD or a psychologist to check their work. What has your experience been?

Dr Isbitsky: I think the problem is not as significant when you have MA-level people working where there are psychologists around to supervise. There is a danger when you have people out in the field practising independently who do not have contact with people who can act as supervisors. As it stands now, we do make impressive attempts to connect with the supervisor. Does that answer the question at all?

Mr J. Wilson: Yes. My concern is that we not put those people who are currently practising at the MA level out of business, because we have had testimony that they are providing a good service.

Dr Isbitsky: As I understand, one of the things OPA has been struggling to do over the years with less response from the ministry than I guess they would have liked, was to establish some kind of qualifying PsychD program for MA-level practitioners who have been out. If you have somebody who has been out practising for 20 years, obviously you cannot discount that experience. There needs to be some way of upgrading them with respect to the current theoretical developments in the field, some of the conceptual developments, so that they are then regulated and licensed to practise as a PsychD. It is a type of doctorate in psychology that would be granted.

To simply say that as there are not enough psychologists around to supervise, we will therefore dispense with supervision, I think the risk there is—

1140

Mr J. Wilson: That is not what I was implying. I was stating that we have had testimony that there is very limited supervision in some areas of the province now.

Dr Isbitsky: That is basically what I am saying, that what the north needs is to attract and retain more regulated practitioners.

Mr Beer: Thank you for the examples in your brief, which did address the question I placed earlier, and those are very helpful.

I think you mentioned in your brief that neither board of education has a psychologist on staff. I believe one of the concerns that psychologists have is that school boards will hire people with other kinds of training, and that is where some of this title comes in, a "psychological consultant" or something of that nature. What is the experience you have of whom school boards or other organizations hire to provide what, in your view, is advice that should be provided by a trained psychologist?

Dr Isbitsky: I would like to turn that over to my colleagues who work more directly within the educational field. I am in clinical practice and I do not have direct involvement. Perhaps Alan can take that one.

Dr Gelmych: Currently there are people employed by both school boards who call themselves teacher diagnosticians. Usually these are teachers who have specific training in test administration; this does not mean they have specific training in test interpretation. These people are often asked to diagnose learning disabilities, for instance, to give those results back to parents and to organize a specific type of treatment response. That is a problem.

Mr Martin: Going off on a tangent, some of the tension of the north, certainly from my experience of having lived here for a while, is around the question of professionals providing services versus self-help groups and communities healing themselves of some of the social disease that sometimes creep in. I wonder if this legislation puts the focus so much on the professionalization of service that it may impact on the ability of a community to do those things through self-help operations which it has actually developed out of necessity over the years.

Dr Isbitsky: I do not always see self-help groups as springing up because there are not the practitioners. Even when you have the regulated practitioners there is a role for self-help groups. There is a range of mental health services that can be helpful to people. It may be that at one time a person will choose to go to a psychologist, but also be referred to a self-help group to get some additional support.

I do not see that restricting the terms "psychology" and "psychological" would in any way stop self-help groups from doing their work. But I still think it is important for the consumer to be able to identify: "This is a self-help group. The people I'm going to be working with are lay people with no specific training, but only that such as I may have as an average person." They may have survived a similar experience and in that way can be very helpful, but they have not studied a particular body of knowledge and had supervised training in application of the science of psychology. I think that in no way interferes with the ability of self-help groups to convene.

Mr Martin: To follow up on that—maybe it is a little different again: I think it is part of the whole package; there are many people in communities in the north who do excellent mental health work because they are caring and have a way about them that is supportive, as people work through some problems. To set up a standard of academic achievement before you can actually practise sometimes inhibits the participation of those people in the profession, because to get an MA or a PhD is such an awesome task and is not always achievable by those who might be best in the field. Can you comment?

Dr Isbitsky: You have to weigh the disadvantages of maybe eliminating some people who are very good but who do not have the academic qualifications and who, with some of the programs we should have, could be brought up to par. There is the danger of eliminating some good people in the service of protecting the public from a whole other bunch of people who may not be good, who may not be supportive and caring, may not have met minimum standards of training.

I think what you are doing is guaranteeing a minimal standard with the title "psychology" and "psychologists" and "psychological." That does not mean the other people are not free to practise; they are free to practise. They are not regulated, and perhaps they should attempt to become regulated.

I think what we are trying to do is broaden the scope of who is able to practise within a regulated framework. It is not meant to ostracize or exclude people. I do not see it that way. There is a place for those people.

The Chair: I ask the committee's consent to ask a couple of questions myself at this point. We can extend the time.

I have three questions that could be answered, I think, simply with yes and no answers that might let you know what I have heard from the committee and clarify some of the points. In fact, I would appreciate yes or no answers if you could do that.

Dr Isbitsky: Psychologists very rarely do.

The Chair: This is around the issue of access to services. Would you agree that people who hold master's degrees in psychology provide psychological services?

Dr Isbitsky: A qualified yes.

The Chair: You agree that they have been providing those services in the employ of the provincial and the federal government since this process began in 1982?

Dr Isbitsky: Again, a qualified yes.

The Chair: Why qualified?

Dr Isbitsky: Because it is going to depend on how you define the whole area of psychological services. Psychometrists are able to do psych testing, which is a psychological service. However, they are not, at this point, able to completely interpret and take responsibility for our psychological report.

The Chair: But they do in the employ of the provincial or federal government?

Dr Isbitsky: I do not really know for sure.

Dr Gelmych: Under the direction of psychologists.

The Chair: The next question I have follows on that. Do you believe it is the role of the self-governing profession to establish the requirements for entry to practice, or do you believe that should be the responsibility of the government?

Dr Isbitsky: Ideally, that is something that should be reached jointly. I mean, they should not be at odds, I would think.

The Chair: Why would you call yourself a self-regulating profession if you want the government to set the standards for entry to practice?

Dr Isbitsky: We do already have in place an act, which we have had for 30 years, that has set the standards for the practice of psychology.

The Chair: And which excludes the master's degrees in psychology.

Dr Isbitsky: But as I understand, there is an agreement that has been tabled to look at that issue, and it is an issue that has been looked at by the associations for a while.

The Chair: The last question is, we have heard that in this agreement they want an additional 18 months to discuss and come to terms with the entry to practice issue. What would make you assume this would be resolved within the next 18 months, as it has not been resolved in the last 10 years?

1150

Dr Isbitsky: It took this committee a long time to get the Regulated Health Professions Act going. You cannot do these things overnight. But I think 18 months is a time frame. It is not indefinite; it is close enough that we have to really get to work.

Dr Gelmych: Most other provinces and states do have an agreement whereby both doctoral-level and non-doctoral-level practitioners have a scope of practice that in some ways overlaps, but is consistent with something that meets both parties' agreement.

Dr Isbitsky: In other words, there are models available for how to do that.

The Chair: Thank you very much. That is the end of my questions. I appreciate your coming before the committee today. I appreciate the committee allowing me to put those questions on the record.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION

The Chair: I now call OPSEU, the last presenters for this morning. You have 20 minutes for your presentation.

Mr Reid: I thank you very much for letting us have the opportunity to address you this morning. With great pleasure, I will introduce the members of my committee. Connie White is a charts technologist in chemistry from Laurentian Hospital in Sudbury. Frank Pezzutto is a charts technologist in histology at Civic Hospital in North Bay. I am an executive board member with OPSEU and I am also a respiratory therapist at Victoria Hospital in London. Amanie Oakley will be taking you through our presentation this morning; she is a registered technologist in biochemistry from Wellesley Hospital in Toronto. Without further ado, I will turn it over to Amanie.

Ms Oakley: It says "good afternoon," but I guess it is still good morning. OPSEU is pleased to have the opportunity to address the standing committee on social development to discuss the implications of Bill 43, the Regulated Health Professions Act. As a union, we represent 10,000 workers and many health care disciplines across the province and we, of course, have considerable interest in this legislation.

OPSEU has recognized for years that the health care workers are a dedicated bunch. We do deserve formal recognition as such, and for this reason OPSEU is pleased that through this piece of legislation these workers will receive the esteem to which they are entitled. There are, however, weaknesses in this legislation which we are respectfully bringing to your attention.

In a previous presentation to this committee, OPSEU voiced concern over the issue of union representation on the soon-to-be-formed colleges and the fact that its members will be barred from the health professions board and the minister's advisory council. That presentation focused on our concerns about disciplinary issues and the missing principles of natural justice. For anyone who missed it, that discussion is recorded in Hansard.

Today we will address the double-barrelled issue related to union representation, and that is the silence on the issue of grandfathering and the lack of distinctions on title protection. As an aside, we will also briefly address our concerns with the performance of controlled acts.

The future of some OPSEU members, primarily laboratory technologists, hangs in limbo because the legislation is silent on grandfathering. Likewise, audiologists, occupational therapists and dietitians, most of whom have formal educational qualifications, may be harmed because there are

few title restrictions and, with the exception of audiologists, no jurisdiction over relevant controlled acts. Although these issues are very closely connected, we will address each individually.

The sole issue of grandfathering may affect anywhere from 5% to 10% of OPSEU health care workers, and thus it is an issue which requires closer scrutiny as a job security issue. By excluding a grandfather clause from this legislation, the government is implicitly questioning the fitness of our most experienced members to practise their profession. Laboratory technologists, the most affected group, have experienced technological and other workplace developments first hand. Yet these people who know their workplaces and their work so well may become victims of a change in values, a change which favours formal academic qualifications over experience. The extent to which they may become victims is severe: They may lose their careers.

A more offensive implication of the government's blind eye towards including a grandfather clause is the suggestion that it is the health care worker and not the system and not the administrators who are ultimately responsible for patient misadventure. This is not the case. Lab errors are infrequent. In quality assurance audits in the laboratory of a local 350-bed hospital, only five incidents were reported in the past year, and of these five only one involved a letter of discipline. This sound record is the rule and not the exception in labs around the province. This clearly indicates that these health care workers are competent and deserve the protection of a grandfather clause.

This is not the first time in Ontario's history that health care workers have been subject to this type of professional review. In 1964, the Radiological Technicians Act was amended to formalize the regulatory body and to define credentials for radiological technicians. These legislative amendments included a grandfather clause which allowed all workers who had been practising in Ontario as a radiological technicians for a period of at least five years and who could pass examinations by the board to continue practising.

It is OPSEU's position that a grandfather clause which is laid out in legislation is more important in 1991 than it was in 1964. The workforce is better educated now than it was 27 years ago and formal educational qualifications are more valued now than they were then. The trend towards valuing academic credentials may now be worrisome. Nobody now knows who will be elected for or appointed to the council committees which are charged with making decisions about testing procedures, and whether they will be biased towards practitioners with more educational qualifications.

According to the legislation, the decisions regarding who qualifies for registration, and how they qualify, lies with the registration committee of the colleges. In OPSEU's opinion, there should be little question regarding who, in terms of current practitioners, are qualified to perform their jobs. As we have said, health care workers are generally a competent bunch. Given the recent crisis in health care, however, we may find ourselves in situations where underfunding stresses current human resources and forces a hand at errors.

Should someone who has been practising a profession for 10 or 20 years suddenly be told that his or her qualifica-

tions are not acceptable in Ontario and that the accumulated weight of his or her knowledge and experience is not considered as valuable as the diploma of a new graduate? Until the last few decades, the work done by our present-day laboratory staff was the domain of the physician. As the workload of the physician expanded, helpers were hired to ease some of the burden. Many of the individuals in today's hospitals in need of grandfathering protection entered the various fields when the professions were in their infancy. As with any growing process, rules were created and amended over time.

While policymakers fretted over requirements and guidelines, these people quietly mastered all the skills necessary to perform their jobs and helped train the newly emerged graduates of fledgling courses. With the maturing of these new graduates, the backbone of expertise provided by the original practitioners became less vital and, as with many other professions, educational requirements began to steal the limelight from hands-on experience.

As a future direction, demands for more stringent educational qualifications may be appropriate, but in dealing with such new professional areas—as we are—those individuals who have been competently practising for a number of years without officially sanctioned diplomas should be excluded from the proposed requirements.

The next area I would like to look at is title restrictions. OPSEU has concerns about the use of job titles which may imply formal qualifications where none exist. If this government is sincere in its attempt to provide more options and protection to the public, we believe there should be restrictions on what people can call themselves. Perhaps the most glaring example of this is in the field of speech-language pathology. Under this legislation, the only protected title for a person in this field is "speech-language pathologist." Ironically, this is not the title which the public, or even the medical profession, is most familiar with. These professionals are more widely known as speech therapists. However, because "speech therapist" is not a protected title, anyone, regardless of qualifications, can call himself a speech therapist, go into business as such and mislead clients into believing he is properly qualified to manage their cases. Clearly, the public runs the risk of being misled and can pay a big price.

1200

It is a further irony that these charlatans, provided they are not performing any controlled acts and provided they do not tag themselves with a restricted title, have less liability to their clients than do licensed professionals. Only a member of one of the college can be brought before its council on a complaint of professional misconduct and lose a licence, a job and a reputation. Where the professional in question is not performing any controlled acts, it becomes even more difficult to make the distinction between the two, because they both have the same scope of practice.

Let's take the example of dietitians. Presently, there are no controlled acts listed for dietitians. This leaves the door wide open for a person who does not have any of the educational requirements or years of experience in the field to call himself, for example, a nutritionist, and in so doing, clearly deceives the public as to his qualifications.

If such a person provides poor advice to a client, he still cannot be brought before the regulatory body of dietitians to answer for his actions. OPSEU believes that the very public this legislation is meant to protect runs the risk of receiving a different type of service than they bargained for.

OPSEU believes it would better serve the public and the professions if the clause first adopted in the report by Alan Schwartz respecting title protection was put back in the legislation. This would make it illegal for any person to take or use any name, title or description implying or calculated to lead people to infer that the person is qualified or recognized by law as a member of the health profession. The public should not be expected to carefully research credentials of health care workers every time they have to seek treatment.

Many members have voiced concerns about subsection 26(1) and paragraph 26(2)1, which prevents them from "communicating to the individual or his or her personal representative a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the conclusion."

Communicating with clients and their families is an integral part of the work done by many of our members. To disallow that would change the context within which most of our members work. This ban on communication would also be inefficient.

Speech-language pathologists and audiologists know better than physicians the source of communication disorders or dysfunctions. Physiotherapists know better than physicians the details of soft tissue damage following motor vehicle accidents. For these professionals to do a workup on a client, then refer the client back to the physician for diagnosis and have the physician send the client back for treatment is ludicrous. It also makes no sense that now, for the first time, physiotherapists can take clients without a physician's referral, but that same physiotherapist cannot give the client a diagnosis of his condition.

OPSEU is well aware that the government had no intention of creating inefficiencies by permitting assessments at all levels and restricting diagnosis. It is not our intention to harp on this, but we wish to make clear the fact that there are conflicting legal opinions on this issue. It is likely that at some point the distinction between an assessment and a diagnosis will be drawn, but it may be drawn at a considerable cost to some members.

It is quite clear that no bill can anticipate all its consequences when it is first drafted. However, over the past two weeks, OPSEU has presented some very well-thought-out and very serious concerns about these bills. We ask that you give them your fullest consideration.

Mr J. Wilson: I certainly sympathize with your comments surrounding grandfathering. My own mother was effectively shut out of the teaching profession for only having gone the normal school route rather than getting a degree when the PhDs took over the teaching even though she has taught for 30 years. I know first hand what that can do to one's salary and one's esteem.

I would ask the parliamentary assistant whether the government has given any consideration to the issue of grandfathering?

Mr Wessenger: I would like to indicate that we also are concerned about the question of grandfathering. The way, of course, we see that being dealt with is under the regulations made by the governing college with respect to the profession. It should be noted that those regulations will have to be vetted through the advisory committee before they are put into effect, and they also, of course, have to be approved by the Lieutenant Governor in Council. We see that through that procedure there would be definite protection. With respect to the whole question of grandfathering, we certainly want to see it dealt with in a fair manner; there is no intention to deprive qualified people of their right to practise in their profession.

Ms Oakley: Could I make a comment on that? I am curious why some cases have been specifically grandfathered, such as chiropodists and so on, and not these professions. It is of concern to us because—I can fax you some of this information—in magazine articles that have been written up interviewing members of our governing bodies, these people make it very clear that education is the be-all and end-all, and that you are not getting it in order to practise better or go up in salary or move forward, but that you should get your ART, for example, which is the next level up, for no other reason than just the sheer joy of it.

I would really wonder whether people like that could comprehend the dilemma faced by some people who have been practising in the field for 10 or 20 years and have to write an exam again when they have not seen a book or that kind of formal education for so long.

Mr Wessenger: I would like to have ministry staff respond to that as well.

Mr Burrows: Just two points: First, the regulations that will be proposed with respect to entry level will be proposed by the interim or transitional council as well, and government will be taking great care to ensure that the transitional council composition is composed fairly.

Second, with respect to grandfathering—you mentioned chiropodists—I would point out that in the case of groups such as osteopaths, chiropodists and so forth, these people are in fact already self-governing. There is a big difference between a self-governing profession—one that is already established by statute and you are lifting it out of one statutory framework and putting it into another—and granting self-governing status to a profession that has not been self-governing where such issues as entry to practice for this self-governing entity still needing to be addressed and vetted in a public way.

The Chair: A question, Mr Owens.

Mr Owens: I think parts 1, 2 and 3 of my questions with respect to grandfathering have been answered.

Mr J. Wilson: You can throw out that briefing note now, Steve.

Mr Owens: I found it rather astonishing to find out that I was turning a blind eye to this issue after asking, in several different venues, questions around this issue.

Anyway, approximately how many folks are we talking about?

Mr Reid: The numbers are probably very small. It is rather difficult. We have tried to find and extrapolate that type of information from the various societies that are around, but they do not keep those types of numbers themselves.

The group we are concerned with most is, as I said, in the laboratory technology. If we look at the history, about 20 years ago there was a great demand to recruit people into laboratory technology, into the different health care sectors, and what they did in that case was advertise outside of the country to places like the Philippines, Great Britain and other areas. They accepted people who came in with American qualifications, from the Philippines, and British qualifications, and also accepted people into the field with a BSc in related sciences. These people are long-term people. They have been working in the field for anywhere from 15 to 20 years and practising as recognized and qualified RTs. Those are the people we are concerned about.

Mr Owens: In terms of what happens in the private laboratories as opposed to hospital settings, is the grandfathering issue still applicable? Should we look at a separation between public and commercial, or should we continue to move forward with grandfathering medical technologists as a whole?

Ms Oakley: I think you are still going to have the same problem in private laboratories. I do not think they will be out of a job, but they may be using that as an excuse for having to pay them less to do the same work.

1210

Mr Owens: In terms of quality assurance and ensuring that the bottom line is protected and the patients are getting the highest standards possible, salary is really a tertiary issue.

Ms Oakley: I have a personal situation going on right now at Wellesley similar to what you are asking about. I was approached by one of the directors of the lab and told that one of the people working in nuclear medicine is not registered here; she is telling me that when this legislation goes through she is going to have to get rid of this person. The person has been working 20 years. I said to her: "Have you had any problems with the person's performance? Is that why you are approaching me?" I was told, no, this is not a performance problem.

As Bob has said, a lot of the time we did experience a severe shortage. People were lured into this field, and now we are looking back and saying: "Maybe that wasn't the greatest idea. We'd better put more stringent standards." That is fine for the future, but if someone has a history of poor performance, that is going to be dealt with in another manner beyond what their credentials are.

Mr Beer: This is probably the sixth or seventh on grandfathering. It seems to me that one of the things it is important to recognize here, though—it was commented on in a question—is that with the new councils moving to set up standards and all that kind of thing, it is a much more public process. The kind of example you have just mentioned is clearly something, assuming that the person is competent and capable, that simply should not, indeed must not happen. I would hope that the very public way in

which those standards would be set would protect against that, at the very least. As you mentioned before, those can be drawn to legislators' attention to deal with. I think it is not going to be a closed room where that will be done. It does not mean there will not be any problems, but it seems to me there is greater public protection.

On the first page where you are talking about grandfathering, would you see a program similar to the one that was done back in 1964 as being a fair way, that they would look at those who were going to be grandfathered and perhaps set certain time frames and/or some kind of tests? What did you have in mind in terms of how those people might be grandfathered?

Ms Oakley: It is not an inefficient way to do it. However, I have to question, since these people have not had any kind of performance problem, the need to do it again—these people, and I feel for them, have been out of school for that entire length of time—unless we had testing that was done specifically for the area they are working in.

I am registered as a technologist in five areas. However, I have only been out of it for five years, and I can tell you the fields I do not use every day are gone. And these people especially, because they often have been relegated to specialized tasks due to their lack of credentials, have been told, "Okay, you're going to take over this particular bench." They do not even know biochemistry—but they may know the special tests in biochemistry. That is my concern.

The Chair: Thank you very much for your presentation. I would like to ask you one question that I asked the previous presenters, if it is all right with the committee. In a self-governing, self-regulatory framework such as this, in your view who should make the decisions on entry to practice and grandfathering, the government or the self-governing boards, councils, colleges?

Mr Reid: We agree with self-regulation as far as the different professions go, but because this is a legislative act coming down, forcing the hand of a number of the different health care professions, therefore, what we are asking in a number of our presentations is that with this legislation and the direction for self-governing the government take responsibility to make sure that the way this self-governing is set up is responsible to the people it is going to self-govern.

The Chair: Supplementary to that, the report on access to trades and professions identified that as a very specific issue, and I think it is of concern to everyone on this committee and all members of the Legislature to ensure that competent, qualified individuals have access to trades and professions, particularly those who chose this country for the opportunities it provides. It is one that I know legislators will be struggling with to make happen, and it is very difficult in a self-governing relationship to know how that should work. I appreciate your comments.

Mr Hope: That is why we need more lay people.

The Chair: That is one, but there is also the obligation and responsibility if you are going to have a level debate.

Mr Hope: So we need more laypeople.

The Chair: That is not necessarily the only answer.

The committee recessed at 1216.

AFTERNOON SITTING

The committee resumed at 1342.

NUTRITIONAL CONSULTANTS ORGANIZATION
OF CANADA

The Chair: I would like to call first the Nutritional Consultants Organization of Canada. You have 20 minutes for your presentation and if you would, leave a few minutes at the end in case committee members have any questions. We have all received your written brief.

Dr Rowland: First of all we would like to offer our congratulations to the team that put this legislation together. We wholeheartedly support its intent, namely that of providing the public with free access to services of their choice, and regulating the practitioners accordingly. There are, however, some inconsistencies that work against the main purpose and actually deny consumers some of the safe health alternatives they now have.

I would like to tell you a little bit about who we are. The Nutritional Consultants Organization of Canada, or NCOC, is a voluntary non-profit association incorporated under the laws of Ontario. We have two classes of membership: first, associate members, people from the general public who are interested in nutrition; and we have a second class of membership, professional members, who are health care practitioners. I speak to you today on behalf of both classes of our members.

We would like to make it clear, in reading over the legislation, that we are not in violation of section 31. We do not falsely hold ourselves out to be a body which regulates, under statutory authority, individuals who provide health care. In all our literature we mention that we are a voluntary association. We do provide the title RNC, registered nutritional consultant, to our professional members who meet our academic and ethical standards for practice. This is entirely a voluntary thing and the title we use is not similar to any of those in the bills that are proposed.

Bill 43 will not change the way we practise. We will continue to operate legally as an unregulated health profession. As individuals we are free to do anything except that which is forbidden by law. We especially welcome the concept of controlled acts. It makes it very clear to us where the boundaries are. Provided we do not commit any controlled acts and provided we do not use any restricted titles, then we are legally free to assess and treat nutrition-related disorders.

Now, there are a few controlled acts that I would like to mention. One of them is paragraph 26(2), procedures on tissue below the dermis. Unless there is an exception stated somewhere that we have not found, this would wipe out the practice of acupuncture. It would give it to medical people who, for the most part, are not trained in acupuncture, never studied it, are unaware of its benefits and are incapable of providing it. Would this proposed section cut these people off, the ones who have been benefiting from acupuncture, or would it drive them into the hands of those who circumvent the law in order to provide a valuable

health alternative not available elsewhere? We suggest that acupuncture be made an exception to this particular section.

Subparagraph 26(2)(vi), among a list of things, mentions that it is a controlled act to insert any instrument beyond the anal verge. Thus, administering colonic irrigations would become illegal if done by other than medical doctors or nurses, who may not be aware of the benefits of this kind of therapy and who would quite rightly consider the performance of it to be a waste of their considerable training. In Ontario there is quite a history, we understand, of individuals who assist others to cleanse their colons of accumulated filth which may be a contributing factor in certain disease processes. These people have been doing it for quite a time and, so far as we know, there is a fair safety record. In fact we do not know of any problems in terms of the safety record at all. If colonic irrigation is to be put into the hands of medical doctors and nurses, then it effectively denies the consumer access to it because it really is a waste of a practitioner's time to go back to school to become a registered nurse to do just this one thing; and the nurses, who are highly trained, have better uses for their skills.

Paragraph 26(2)(4) refers to spinal manipulation, and our concern is here as well that the chiropractors have this as a controlled act, but we do not understand how medical doctors can have this as a controlled act under their scope of practice. Spinal manipulation is not a subject that is taught in conventional medical schools. We understand of course that osteopaths are to be included in the Medicine Act, but what protection do individuals have against potential injury from spinal manipulations performed by doctors who, although legally permitted to perform them, have neither the training nor the skill to do so safely or effectively? That is our concern. The way it is worded, it is open-ended; medical doctors can do it.

Paragraph 26(2)(5) restricts administering any substance by inhalation. It would therefore prevent unauthorized practitioners from using therapies which rely on the inhalation of steam, dilute eucalyptus oil or the vapours or aromas of other harmless substances. We respectfully recommend that the wording of the paragraph be changed to read, "Administering any substance by injection or administering any drug by inhalation" where "drug" is defined according to the definition proposed under paragraph 26(2)(8).

Paragraph 26(2)(7) restricts certain forms of energy, but these are unspecified. Nowhere in the proposed regulations can we find any definition of the forms of energy which are proposed to be restricted. To be made into a law this way, it is like giving legislators a blank cheque to fill in the forms of energy later on. Obviously the administration of X-rays, gamma rays and the like need to be limited to qualified practitioners, but what about innocuous and subtle forms of energy such as magnetism and electroacupressure? We respectfully suggest that neither we nor our elected representatives can know what forms of energy are to be permitted or restricted unless they are specified in Bill 43 before it becomes law.

Paragraph 26(2)(8) defines a "drug"; it defines it according to clause 113(1)(d) of the Drug and Pharmacies Regulation Act, but to our knowledge there is no such act as yet. It has not received its first reading. Now if clause 113(1)(d) in the Drug and Pharmacies Regulation Act is identical to clause 113(1)(d) in the Health Disciplines Act—Pharmacy, then we have no problem, but this needs to be spelled out.

Section 30 would restrict the title of "doctor" to chiropractors, optometrists, medical doctors, psychologists and dentists. Such restriction discriminates against holders of legally valid doctorates in other health care fields and against unregulated health professions which have just the same legal right to practise and are just as legally valid as those groups to be regulated by Bill 43. The title "doctor" was originally used for centuries as a term for a teacher or a learned person before we used it to describe medical and health care providers, so we have some questions. Would someone with a PhD in biochemistry, for example, who wrote a book on taking vitamins, not be allowed to call himself "doctor" because the book could be construed to be giving advice to individuals on their health care? Certainly individuals would rely on the things that were said in the book.

We would like to point out that legally valid doctorate degrees are awarded in health care fields in specialties other than the five listed in section 30, by legally valid institutions which have the legal right to award such degrees. Examples include doctor of naturopathy, doctor of acupuncture, doctor of homeopathy and doctor of philosophy degrees in such fields as biochemistry and nutrition. Those seeking health care have the right to know what qualifications and training a given practitioner may have in his or her field. One common way of doing this is for the practitioner to display his certificates or diplomas on the wall. Now if we have a practitioner who cannot legally call himself doctor but has to have a legal doctorate hanging on his wall, can he not refer to that? Can patients not refer to that? Is there some kind of restriction on freedom of speech? It is a fact that he has had this training, and the patient or client or participant has the right to know about this.

We respectfully recommend that section 30 be revised to the following, "No person shall use the title 'doctor' in a fraudulent or misleading manner, or in any way that wrongly implies that said person has skills or authority which he or she does not in fact have." In this way, it seems to cut off all the conceivable abuses of the title without denying people the legal right to refer to the training they have had.

1350

Section 3 of Bill 51, the Dietetics Act, which is mentioned in schedule 1 of Bill 43, says, "The practice of dietetics is the assessment of nutrition and nutritional conditions and the treatment and prevention of nutrition-related disorders by nutritional means." As such, we find it extremely misleading to the general public. It proclaims skills which dietitians do not have. It confuses the terms "dietetics" and "nutrition," which most assuredly are not the same. The main emphasis of dietetics is on mass feeding. Dietitians are responsible for the menus in hospitals, prisons and other institutions. Some are employed by food

companies; some are also employed by community public health departments. According to an earlier submission by the Ontario Dietetic Association, only 5.6% of dietitians in Ontario are employed in private practice, and some of these work as self-employed consultants to food processing companies. Very few dietitians counsel individuals.

Dietetics is a narrow subcategory of the much broader field known as nutrition. Its emphasis is on measuring one's food intake in such terms as it adheres to the four food groups, counting calories and so on. It assumes that all people are the same. It does not take into account that each of us is biochemically unique, that our metabolisms differ, we absorb nutrients at different rates, we have different requirements and so on.

We respectfully suggest that individuals who seek the services of a dietitian for assessment of nutritional conditions and the treatment and prevention of nutrition-related disorders may be misled as to what to expect when actually consulting a dietitian. We respectfully recommend it would be a more accurate presentation of the truth to change the wording of section 3 of Bill 51 to, "The practice of dietetics is the assessment of diet and dietary conditions and the treatment and prevention of dietary-related disorders by dietary means."

In conclusion, I would like to say that our proposed amendments will strengthen Bill 43 by eliminating inconsistencies and inequities before it becomes law. To deal with them after the fact would be costly, ineffective and wasteful of health and human resources. Bill 43 has the potential to create a health care system that is second to none, giving consumers ready access to safe therapies of their own choosing. It has the potential to eliminate monopolistic practices in the health care field, thereby opening the door to both greater competition and greater co-operation in providing needed services.

One thing Bill 43 will do is protect alternative and complementary practitioners from the risk of being charged with practising medicine without a licence. Henceforth, entire professions are not to be licensed. Only specific acts deemed to be harmful if performed by untrained personnel are to be controlled. By avoiding all unauthorized acts, all practitioners from every health field can legally assess, treat and prevent disorders without fear of persecution. We predict that the favourable climate created by Bill 43 will place more emphasis on preventing diseases and less necessity on last ditch efforts to cure them once they have taken hold, with resultant savings in suffering, potential lives lost and health care costs. We sincerely hope that other provinces in Canada will enact legislation similar to Bill 43.

Mr Beer: First of all, I really do want to thank you for an excellent brief. We keep talking about the members of the committee having a steep learning curve about a lot of things that we do not know about. I think you have pointed to a number of issues, some of which have come up before, but a number which have not. I think it is fair to say—and perhaps I have a question, but maybe later the parliamentary assistant could comment—that some of the things such as acupuncture indeed will not be wiped out, that there is a process by which they will be exempted or regulated or somehow dealt with.

Dr Rowland: Will this include colonic therapy or just acupuncture?

Mr Beer: The only one I know of at the moment is acupuncture. I will put it as a question at this point. Are there any others on that list that specifically are going to be dealt with?

Mr Wessenger: I will ask ministry staff to reply to that.

Mr Beer: It seemed to me it was acupuncture. I know spinal manipulation has been raised by the chiropractors. We have been looking at that. I thought there would be a process for forms of energy as well.

Mr Burrows: Yes. With respect to acupuncture, there is a specific commitment that there will be an exemption under the authority to grant exemptions. We expect that would resolve that problem. With respect to colonic therapy, I think this is subject to further discussion. Unfortunately, I was not present yesterday. There was a presenter on the subject, and I do not know what discussion took place with the committee or if any commitments were given; but you are absolutely right that a specific exemption would be necessary, and I expect the committee would be considering the evidence put before it. I would certainly agree that for now pressure, based on the evidence that I have seen, there is not much evidence of harm.

In the case of spinal manipulation, I think the health professions legislation review was convinced that this was a potentially hazardous procedure, but it is recognized that more than one profession does perform this act or some variation of this act. It is one of those areas where the extent of the manipulation really is an important factor. But I would point out that, under this legislation, all the health professions will be required to have mandatory quality assurance programs. One of the questions we expect to flow from that over time is that each college will say of its members, "Although we have this range of licensed acts, are all of our members capable of doing all of these things?" We expect a natural evolution here. But certainly there is no doubt that some physicians do spinal manipulation. I do not think there is any evidence to show that is particularly more hazardous than other practitioners performing it.

Mr Rowland: So the protection to the public will come through the college which regulates the physicians?

Mr Burrows: Yes, it will be up to the college to determine whether or not physicians are doing the right thing in that respect.

The Vice-Chair: Could I move on, since we have a fair number of people who would like to ask some questions. Mr Owens.

Mr Owens: I would like to find out a little more about the designation "registered nutritional consultant." How does that compare to the dietitian and what sort of functions would the RNC perform versus the dietitian, and where would you folks practise?

Mr Rowlands: Our professional members provide nutritional counselling services primarily to individuals. Most nutritional consultants are in private practice. Some work in conjunction with chiropractors, naturopaths; some, of course, with medical doctors and so on. Some work in

conjunction with only the health food stores and so on, but primarily they counsel individuals.

The RNC certificate is simply something we, as a volunteer association, award to our members who have met our standards. We insist either on a bachelor's degree in holistic nutrition, which is quite different from dietetics, or its equivalent. If a person does not have a background that we consider important, then we suggest some courses they can take to make up the difference. We assess each person on his or her own merits. You are really asking two questions, you know, the certificates and the type of practice.

Mr Owens: Where would one obtain that bachelor of holistic nutrition, that type of education? Is it carried through the College of Naturopathy or is it in the States?

Mr Rowlands: All those who have bachelor of nutrition degrees get them in the United States. There are no colleges in Canada that offer that kind of thing exactly. We do, however, have some graduates from the University of Toronto, I think the University of Waterloo and the University of British Columbia, who have taken the mainstream nutrition degree programs and then have gone on to specialize and to do further study in what we consider to be holistic nutrition. Our effectiveness comes from varied backgrounds. As yet, there is no college in Canada that offers exactly the course we need.

1400

Mr Hope: Just one question dealing with colonic therapy and your comments. Not being an expert myself on all those acts, could you elaborate a little bit more?

Dr Rowland: I have a copy of the present act, the Health Disciplines Act—pharmacy. Clause 113(1)(d) defines a drug. It is quite a lengthy definition, which includes anything, and then it says "except, except, except" the things referred to in certain schedules. We have gone over it with a fine-tooth comb and this is great. What it is really regulating are controlled prescription kinds of drugs. But the act that is proposed, that is mentioned in Bill 43, is not in law yet, so we are assuming that this is going to be the identical definition. But is it? That is our concern.

Mr Wessenger: I think ministry staff can clarify that whole question about definition of drugs.

Mr Burrows: The existing definition and all other things pertaining to the regulation of pharmacies and drugs—not pharmacists, because this legislation deals with professionals—will be simply lifted out of the existing Health Disciplines Act and retitled. That is all this proposal does, so it is neutral on the question.

Dr Rowland: Great. That was our assumption. I just wanted it clarified.

Mr J. Wilson: Great clarification. I will have to get a copy of the Hansard.

Mr Johnson: A very quick question. With regard to "who we are," I see this organization was incorporated in 1983. There must be a companion organization, I am assuming, in the United States. I was just wondering—this advisory board, are these people Americans or Canadians? I see Linus Pauling there. Would that be Linus C. Pauling, the physicist?

Mr Rowland: The twice Nobel laureate, yes, it is. There is no exact counterpart to our association in the United States, to our knowledge. There are two or three associations, some have come and gone, and we are not sure of the status of them. This is an independent Canadian organization. On the advisory board we have Dr Abram Hoffer, a noted Canadian; we have Jan de Vries, who is from Scotland; and the rest are from the US. These are people with whom we have developed associations and who have contributed significantly to the field of holistic nutrition.

The Chair: Thank you very much for your presentation. If there is additional information that you think would be helpful to the committee during our deliberations, please feel free to communicate with us in writing; just address it to our clerk.

Dr Rowland: Thank you. What deadline would we have, or have you decided?

The Chair: We expect the committee will be considering the bills, clause-by-clause, after the Legislature resumes, and that date is September 23. We will be likely, through the month of October, examining the bills during clause-by-clause debate. We cannot give you a time line exactly because it will depend on the numbers of hours required to do clause-by-clause.

Mr Hope: Co-operation.

The Chair: And Mr Hope mentions co-operation of committee members, which I am sure we will have. Thank you very much.

ONTARIO SECONDARY SCHOOL TEACHERS' FEDERATION, SUDBURY

The Chair: I call the Ontario Secondary School Teachers' Federation, Sudbury branch, District 31. You have 20 minutes for your presentation.

Ms Peloso: Thank you, Madam Chairperson. I would like to thank the standing committee on social development for taking the time to obtain all this input from various areas of society regarding this legislation, especially in this hot weather. I am sure you would rather be anywhere else but here.

The Chair: We have had a warm welcome.

Ms Peloso: You have had a warm welcome in the Sault. You would have just as warm a welcome in Sudbury, I am sure.

I am Mary Ann Peloso and I am a speech and language pathologist. I am the secretary-treasurer of the professional student services bargaining unit of the Ontario Secondary School Teachers' Federation, District 31 in Sudbury. My colleague is Dr Brian Burt, who is a psychologist, and he is the president of our professional student services branch of OSSTF.

We were quite excited about this opportunity to be able to present a brief together, being from two different professional backgrounds—a psychologist and speech-language pathologist—who sometimes can be at loggerheads, but in our instance we are not. We work quite well together in very collaborative system delivery models for our school board.

We applaud the principal aim of the Regulated Health Professions Act and related acts to ensure the protection of

the public within the scope of the services provided under the auspices of the Ministry of Health. However, we represent professional groups who, although we have the same professional titles as our colleagues who work in health, work in a number of different ministry areas such as education and community and social services, as well as private practice. We have some questions and some concerns about how this legislation will impinge on our roles and positions in education.

This is particularly critical at this time when a lot of effort is being put forth by the provincial government to try to co-ordinate services among the different ministries. I point out Memorandum 81 as one of the pieces of legislation that is attempting to do this very thing, to facilitate health services being delivered within education.

Another recent document, *Children First*, in November 1990, addressed to the Minister of Community and Social Services, is really attempting to co-ordinate efforts for children across the different ministries. I will quote one of its recommendations found on page 59 of that document: "There must be a single major physical centre that operates as a hub of services for children within each community. Where possible, the school should be this centre for service provision."

And another quote from page 56 of its recommendations is: "The provincial government should promote models of service integration and collaboration that simplify access to service and rationalize the roles of our limited resource of trained specialized service providers." In northern Ontario this is certainly true, that we have very limited resources and we have to really be very careful how we make use of that limited pool and how we can facilitate their working together most effectively.

The sections of the legislation that we will be addressing in this brief, which we feel are likely to impinge upon our roles as effective professionals working in education, are the controlled acts section of Bill 43, section 30 that was referred to in your previous presentation and the restricted titles and representation of qualifications subsections of both Bill 44, for audiologists and speech-language pathologists, and Bill 63, for psychologists.

The one section that, as speech-language pathologists, we are most concerned about is the controlled acts, Bill 43, paragraph 26(2)1. The controlled act of communicating, which reads, "Communicating to the individual or his or her personal representative a conclusion identifying a disease, disorder or dysfunction..." etc, etc, is a controlled act that is proposed for psychologists and physicians, but not for speech-language pathologists.

We feel that not being able to communicate our findings—since we are being legislated to be able to assess and to treat communication disorders but we are not being legislated to be able to communicate our findings—will severely inhibit our ability to work as part of a multidisciplinary team in the educational setting.

Speech-language pathologists represent a body of knowledge and expertise that is important for the diagnosis of communication disorders. Speech-language pathologists are equal members of the multidisciplinary team serving children and adolescents in the school setting. Consequently

they should be able to communicate their findings directly. To deny speech-language pathologists this role would very likely result in the downgrading and possible demise of this profession in Ontario.

We recommend that the act of communicating be included as a controlled act for speech-language pathologists. Specifying the conclusions to be communicated should prevent impinging on the professional responsibilities of psychologists or physicians.

Section 4 of Bill 44 should be revised to include, "In the course of engaging in the practice of speech-language pathology a member is authorized, subject to the terms, conditions and limitations imposed on his or her certification of registration, to communicate a conclusion identifying a communication disorder or dysfunction relating to articulation, voice, fluency, or language difficulties."

I will turn the floor over to my colleague, Dr Burt.

1410

Dr Burt: I am going to speak to the subject of restricted titles and the representation of qualifications for our two professions. The problematic wording in subsection 15(1) of Bills 63 and 44, which apply to psychologists and speech-language pathologists, in our opinion is restriction of the title users to health care. Health care could be interpreted to apply to psychological, speech-language or audiological services supplied by professionals funded in some fashion by the Ministry of Health. For psychologists, health care might also be interpreted in the sense of mental health services without any consideration of funding of the provision of the services.

As outlined by the Ontario Board of Examiners in Psychology in a letter to Ms Cathy Fooks in April 1991, "health care" is a term that will certainly exclude many applied practices of psychologists. Most glaring examples, in the opinion of the Ontario Board of Examiners in Psychology, would be the practice of industrial or organizational psychology. It might very well turn out, though, that the practice of school psychology might be interpreted by the courts not to constitute health care.

The additional qualification of title restriction in subsection 15(2) of both Bills 44 and 63 also, at first glance, might suggest that the membership in the College of Psychologists of Ontario or the College of Audiologists and Speech-Language Pathologists of Ontario might act to naturally restrict title usage and consequently expand beyond the health care focus I was just alluding to into other obvious applications of these two professional fields. This could certainly diminish concerns such as ours. However, this additional qualification could be legally interpreted as being inconsistent with subsection 15(1), with subsection 15(1) possibly superseding subsection 15(2). We are certainly not lawyers in terms of the interpretation of such acts, but we do have this possible concern.

It is recognized that the stress on uniformity in the wording of the sections across the professional acts accompanying Bill 43, such as the one on title restriction, does hold appeal, the appeal being simplicity in this case. The focus of the bulk of professional services offered by different professions covered in the professional acts is

likely what prompted the inclusion of the health care provision in subsection 15(1). However, applied psychology and speech-language pathology are by no means restricted to health care as are the majority of the other regulated health professions.

For instance, school psychologists, whom we are representing, account for approximately 15% of all psychologists practising in Ontario; I refer you to appendix A. Speech-language pathologists working for school boards constitute even a larger percentage, 27% of all speech-language pathologists employed in Ontario; I can refer you to appendix B. In addition to these professionals working in private practice or in industrial-commercial applications, they are employed under at least three ministries aside from the Ministry of Health, as Mary Ann was mentioning before, the three other ministries being Education, Community and Social Services, and Correctional Services.

Aside from the foregoing concerns relating to the restriction of title, psychologists and speech-language pathologists in general have a concern about the protection of title. Subsection 15(1) could be interpreted to mean that the restriction placed on the use of titles could permit unregulated practitioners with little or no training to hold themselves out as psychologists or speech-language pathologists as long as they did not provide service that could be interpreted as constituting health care.

Such a situation could ostensibly develop in the provision of school services, where a person not belonging to one of the colleges, or for that matter not possessing any training in these areas, could represent himself or herself as a school psychologist or speech-language pathologist. To the best of our knowledge, a definition of health care is not provided in Bill 43 to clarify this matter. Subsection 15(2) could also be interpreted as prohibiting individuals only from holding themselves out as members of these colleges. Current practices of distinctly holding oneself out as a provider of psychological or speech-language services could therefore be continued, such as using the title "psychologist," providing health care was not being provided or using descriptors in their titles with the "psycho" prefix, such titles as "psychological associate," "consultant in psychology" or "psychotherapist."

A limitation within title protection in subsection 15(1) of Bill 44 is the omission of the title "speech therapist." "Speech therapist" is a title that is used quite synonymously with "speech-language pathologist" in northern Ontario, so we do have a problem in terms of public perceptions of speech therapists.

The recommendations we are offering in relation to restricted titles and the representation of qualifications are:

First, the phrase "to provide, in Ontario, health care to individuals," in subsection 15(1) of both bills 44 and 63 should be amended to read "to provide services in Ontario" to make the title usage less restrictive. We are only referring here to psychologists and speech-language pathologists.

Second, the title "speech therapist" should be added to subsection 15(1) of Bill 44.

Third, the amended wording for subsection 15(2) of Bill 44 that is recommended by the Ontario Association of Speech-Language Pathologists and Audiologists, and has

been outlined in the working document put forward by the committee working on the health professions, is also supported. That wording is, "No person other than a member shall take or use any name, title or description implying or calculated to lead people to infer that the person is qualified or recognized by law as an audiologist, speech-language pathologist or speech therapist."

Fourth, furthermore, the stance of the Ontario Board of Examiners in Psychology is that section 15 should be expanded to include another section to further protect the title of "psychologist" as necessary. This wording is, "No person other than a member shall use any designation or description incorporating the words 'psychological' or 'psychology,' a variation or abbreviation of them in the course of providing or offering to provide services in Ontario."

The last concern we all relate to refers to the restriction of the title "doctor," as we have heard in the previous presentation. We certainly have similar concerns in so far as people using the term "doctor" in an academic sense are concerned. The restriction of the title "doctor" is certainly a major source of concern to speech-language pathologists in the province. Section 30 of Bill 43 limits the use of the title "doctor" to five professional colleges, but speech-language pathologists are not covered in this listing.

Thus, speech-language pathologists or audiologists possessing a PhD would not be allowed to use the title in the provision of the services although his or her qualifications were at the same level of training as the psychologist who earns a doctorate degree. Since this is an earned academic title, the restriction of the title "doctor" in the provision of speech-language services is deemed to be discriminatory and cannot be justified. Members of the college of audiologists and speech-language pathologists who have earned a PhD should in fact be allowed to use the title "doctor." Our recommendation is that the college of audiologists and speech-language pathologists be added to the group of colleges in Bill 43 to be allowed to use the title "doctor."

In concluding, we as representatives of the professional school student services personnel of the Ontario Secondary School Teachers' Federation do strongly recommend the amelioration of concerns of the professions of psychology and speech-language pathology working in education relative to the impact of the Regulated Health Professions Act. The continuation of effective services for students with communication difficulties, for instance, would be hampered by not allowing speech-language pathologists to communicate their findings.

In a more general sense, protection of the public will be jeopardized if title protection is only applied to health care. The speech-language title is currently not being protected and the use of other terms implying other qualifications is allowed.

1420

Mr Owens: Just a quick question after that rather thoughtful presentation: I am just wondering, should this committee agree to accept your recommendations, how would this benefit the kids and the families the kids come from?

Dr Burt: Right now in the provision of our services we have to give, in a very general sense, considerable thought to the types of services we are providing students within our board. We are essentially accountable to parents and students through my current college, if you will, the Ontario Board of Examiners in Psychology. I am essentially being policed in my actions in my care in the school system. In that sense, I feel the optimal psychologically related services are being afforded to students.

We do have people who work for school systems at the current time who do hang out the prefix "psych" in their name, such as psychometrists, who are not supervised by a registered psychologist. I have personally seen a number of practices that have occurred in such cases that I certainly would like to have been able to correct. I have had no avenue to correct that, whereas if it were a peer, another psychologist, I would have been able to approach him as a peer, offer my counselling and, if that counselling had not been followed up, then taken the next course of action, which would have been reporting him through the Ontario Board of Examiners in Psychology.

Mr Owens: So what you are suggesting, then, is that these changes would ensure standards of practice and a level of quality assurance, again benefiting the kids and the families?

Dr Burt: Yes, outside the provisions of health care, such as within the field of education.

Mr Beer: My question is also in the area of psychology. We have had a great number of presentations from speech-language pathologists, so I appreciate the issues you raise. I think those have become clearer, at least in my head. The question I would like to ask you follows on some of the discussion we had this morning with other psychologists. One of the questions has been that only PhDs are members of the college. Would part of the overall problem we are dealing with be helped if MAs could become part of the college and come in under the whole regulatory scheme? I wonder how you would answer that question and how that would affect particularly the provision of psychological services for schools.

Dr Burt: I am not sure if it would be too complicated a system. We certainly have been considering the master's level of service provision in a regulated manner in some sense. We have been toying with the idea of whether it would be best, first of all, looking at this strictly in terms of titles, to consider them more as associates or as assistants, and incumbent upon this would be the amount of training and the amount of education that would be responsible to faithfully represent those sorts of titles. Second would be the amount of supervision that would be required by a psychologist. We are viewing this sort of relationship in a sense where we still do feel that a psychologist would be ultimately responsible in some sense.

In terms of regulation of master's level degrees, I am not sure exactly whether this could be furnished within Bill 63 as such, being addressed as an entity. I would have a lot less reservation about that than I would about such a profession or a capacity being represented under a different bill wherein they would essentially be treated in a truly

autonomous fashion and would not be in some fashion accountable to psychologists.

MICHAEL HAMILTON

The Chair: I call Michael Hamilton. You have 10 minutes for your presentation. Just for the information of committee members, Dr Hamilton is presently the chairman of the Sudbury district health council. He is not here in that capacity today, but I thought you might like to know that.

Dr Hamilton: Thank you, Madam Chair. It is a pleasure to see you again and to appear before you this afternoon. Welcome to the north on such a warm day. My name is Michael Hamilton. I am a native northerner. I am proud to be an Ontarian, and I think that we live in the best country in the world and have the best health care system in the world, and I would like you to know that we in the north are very appreciative of the services we have here.

I am here to address you on—you will forgive me, I hope, for my candour; I will get right to the point as northerners often do—two provisions, one regarding the Denturism Act, another regarding the Dental Hygiene Act. I should declare, first, that I have a conflict of interest in that I am a dentist, and I know we are all very interested in conflicts these days. However I am no longer in the general practice of dentistry, and I now make my living representing the dental public health interests of the population in midnorthern Ontario. I work at the health unit. My interest is not financial at all in this, and I would like you to know that. As Madam Chair has said, although I do represent the Manitoulin-Sudbury District Health Council in other ways, I am not here on behalf of the council to speak to you.

One of the guiding principles that Mr Schwartz used in 1982 in the legislative review with regard to the health professions was that consumers should have a freedom of choice within a range of safe options. That is something that is important for you as legislators to remember, that whatever transpires as a result must be safe for the consumer of those services. I do have some concerns with regard to those two acts.

I would like to go on record as being very supportive of the legislation. What this is all about in the health system is accountability to the public, and that is exactly what is being done with this legislation as it is proposed. We are making providers of health services more accountable to the public, and that is what we need to do and continue to do if we are going to improve services in the future.

I draw your attention to the second page of my submission, and I will get right to the point. Under the Denturism Act there is a proposal that denturists—and I presume you know who denturists are by this stage; if you do not, please query me during the question period—will be able to fit, dispense and order partial dentures. That is different from the present practice where they can make full dentures for people. Of course, the problem becomes one of the foundation for those partial dentures, because a partial denture is a denture where there are teeth remaining in the mouth.

The point that I would like to make to you is if indeed a person has not had a suitable assessment beforehand, an examination and a diagnosis, there is a risk to that person's

dental health of having a partial denture placed. It is akin to constructing a new house on a foundation that has not been properly assessed or diagnosed, or, in northern terms, to sinking a mine shaft without really having a look at what is down below. It is costly in the long run, and in the short term it can be very, very dangerous.

The easiest solution to the problem is not to restrict denturists from making partial dentures. No one is saying that, and dentists certainly are not saying that. The solution, I believe, is to make sure that consumers have had adequate assessment examination and a diagnosis that a partial denture is the best treatment for that person at that particular time. I submit to you this would be one way you could protect the public interest.

1430

Under the Dental Hygiene Act, dental hygienists have, for the last 25 years or so since dental hygienists have been trained in community colleges, been very effective members of the dental preventive team. I can tell you as a public health person that the dental public health in Ontario is among the best in the world. It is the best in Canada. I can tell you that 50% of our young adults, our teenagers now, have never had a cavity. That is something we can be very proud of. But if you think of our generation which is one step or two steps up from that we have many more problems.

Under the Dental Hygiene Act, there is a provision that dental hygienists would be able to establish independent practice. This has been tried in several states in the US, and frankly it has not worked. The reason it has not worked is that people realize services that could be provided in the independent hygiene practices are very limited. They are basically tooth cleaning. That is essentially why people would go to an independent hygienist.

The system is working very well, and I am somewhat worried about fragmenting the system more if we allow the independent practice of dental hygiene. In public health, I have eight hygienists who work not for me but with me in providing the best possible dental public health services in northeastern Ontario.

I submit that what we should be doing is looking at continuing that interplay and making sure that we do not allow the system to be fragmented any more. The current practice in public health is that hygienists can operate under the order, direction or supervision of a dentist. In fact, yesterday dental hygienists working for me were out at one of the seniors' homes up the street while I was back at the office downtown, working under my direction, independently, on their own, but making sure that what was being done for those patients in the homes was appropriate. That is the way the standard is now and I would be worried if it changed much and hygienists were able to go out and operate totally on their own, not taking into account medical conditions of patients and so on.

Those are the two concerns I have. I think probably a change of some of the wording would be all that would be required under the Denturism Act and under the Dental Hygiene Act. That is my submission to you. If there are any queries, my consultations are free. They always are in public health. I would be happy to try to answer them for you.

Mr J. Wilson: We certainly appreciate at this late stage in our hearings your sense of humour. You mention something that was not really the teeth of your presentation, but you mention that the public will be—

Dr Hamilton: Good line.

Mr J. Wilson: I had to write that one down.

The Chair: Hansard will strike that.

Mr J. Wilson: I am already a minority on this crew. You mention that the public will be better represented on professional councils. We have had some professionals appear before us, representing professions, indicating that they felt that, with the new requirement of just under 50% public representation, it may erode the principle of being a self-governing profession. Do you want to comment on that?

Dr Hamilton: To that I would say, so what?

Mr J. Wilson: I thought you would probably say that.

Dr Hamilton: Consumers are the ultimate beneficiaries of the services provided by the health care professions and if we do not have enough consumer input on our councils, then we are not going to get the kinds of services that people want to have. I think we have been remiss historically in not having more consumers on our councils. Certainly other councils—the boards of health, the district health councils—have always had consumers giving input. I would support that totally. We are here really as providers, but for the consumer.

Mr J. Wilson: I thought it had been interpreted by the courts that when you are doing supervision, or whatever the current terminology is—for instance, your example of the dental hygienists being up the street—you were supposed to be on the premises.

Dr Hamilton: No. In public health in designated spots—I am not sure of the actual regulation, the number or anything—it says “under the direction or supervision of a dentist,” and “supervision” means physically on the site.

Mr J. Wilson: Right.

Dr Hamilton: But it says “direction” or “supervision,” so that as long as I can show, as a dentist, that the hygienists who are working for me out in the field have had adequate training, know what they should be doing and can do and have a standard procedure, then there is no problem. The Royal College of Dental Surgeons has recognized that. Otherwise, we would never be able to have public health dental services because it would be physically and resource-wise impossible to have a dentist to screen schoolchildren, to go out into collective living centres and to hospitals, etc. We use auxiliaries. It is cheaper for the system and it also results in just as good service.

Mr Owens: Regarding persons having to have a dental examination prior to having a partial made, philosophically I do not have a problem with that. My only question is, how would you go about defraying the cost of that dental examination for a significantly large portion of our population, and seeming to grow every year?

Dr Hamilton: That is a hard one, and I am not sure how you can answer it. We do not want to milk the public purse any more and say that we will pay for an examination

like that. I think probably what could be built in is some sort of a procedure code or a fee in the dental guides so that people would say, “We’re coming in for an assessment because we’re expecting to have a partial denture made”; something like that, and we would have some sort of a structure in place so that people would know that.

I am not sure about your second comment. I do not feel that there are that many millions or thousands of people who need partial dentures these days. Certainly, the standard of dental care 30 or 40 years ago was not to have teeth filled, and that is what people expected; they would have extractions. But I will bet my bottom dollar that most of the people sitting in this room have almost all of their own teeth, and we are a good example of the Ontario population. It is only our older people who do not have many of their own teeth.

Mr Johnson: Lots of silver.

Dr Hamilton: Lots of silver. Well, silver is fine. There was an article in the paper this morning about the mercury that is the problem.

Mr Beer: Your timing is perfect. I have to confess that I do not have all my teeth.

Mr Owens: Which ones, Charlie?

Mr Beer: That is for you to determine.

I would like to raise a question about the dental hygienists, and the whole question of the future direction of health care, the decentralization in the homes, communities and so on. In a practical way I do not see how, as we move on with long-term care, you could look in the mirror even under public health, and say to yourself “I am still really directing the work of these dental hygienists” in any way that had legal carriage. Is there not some way that we can define the role of dental hygienists so that those sorts of services would go forward? Or do you just fundamentally believe that simply by way of training they are not able to do that, because it seems we are going to run into a major problem there?

Dr Hamilton: I think if you do that you may have to separate dental hygienists employed in private general practice from those who are employed on their own. I do not think you want to do that. You likely would have to have separate training programs.

I disagree a little bit with the suggestion that hygienists who are out in the field in long-term care, let’s say, are not appropriately directed, because they have, in many cases, more strict guidelines than in a dental office. There are policy and procedure manuals; they know exactly what they are; they say, “This is what you must do, must do, must do.” They know that if there is anything that is outside those boundaries they will consult me by phone or wherever I am—they can always get hold of me—and ask. I think the intent of the legislation was to make sure that we were able to use auxiliaries above and beyond just dental offices.

Mr Beer: And you do not think that could be handled through the College of Dental Hygienists of Ontario, where they themselves, as responsible professionals, would recognize that “Beyond this point our practice cannot go and we would have to refer back”?

It is as though we, as women in a profession consisting mainly of women, are not deemed worthy enough to have the choice, the right to say no. It is important and necessary for those people who do have the power to initiate legislation and/or regulations to believe that we as nurses have as much right to our beliefs as, for example, the Sikhs who created so much national turmoil over their turbans. I would think we would be worthy of as much interest.

The words we are trying to convey, basically, are that freedom of personhood and democratic rights should know no boundaries in this country and in this province. Prejudice, bias and perhaps fear of the unknown are the only blocks which prevent us from attaining what is already inherent to all of us in the Charter of Rights, but seems to be excluded from us because of our profession. This to me is discrimination and our proposal should provide adequate protection within the bill for all who require it in the health profession.

Such protection should involve two elements, and this is what I believe should be brought into regulation. The first is the protection of conscience. No person should be compelled directly or by threat of penalty to be an unwilling participant in an abortion procedure or any procedure which would deliberately end the life of another human being.

The second is the right to protection against discrimination. No person should be impeded in his or her career path by an exercise of personal conscience. Both of these elements are necessary, I believe, to ensure adequate protection for nurses.

We offer four reasons in support of special protective legislation. The first is consistent with the spirit of the Canadian Charter of Rights, as I mentioned, specifically in sections 2 and 15 of the charter which guarantee that everyone has the following fundamental freedoms: freedom of conscience and religion and freedom of thought, belief and opinion.

Also, every individual is equal before and under the law and has that right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age, mental or physical disability.

These provisions might be thought to offer nurses some protection. Unfortunately, it is not clear whether they apply to hospitals, especially in the area of employment relations. Even if hospital action is subject to review under the Charter of Rights, there are no decided cases that clearly establish protection for conscientious objectors nor, to the best of my knowledge, are there any cases pending in the courts on this issue at this time. The absence of expressed protection creates uncertainty which discourages nurses from asserting their rights. That is why legislation is needed to clarify the matter.

Protection for nurses is also consistent with the spirit under the provincial Human Rights Code under sections 10 and 14, which provide that, "Every person has a right to equal treatment with respect to employment without discrimination because of creed," and following as well, "Every person who is an employee has a right to freedom from harassment in the workplace by the employer or agent of the employer or by another employee because

of...creed." It goes on to mention and to clarify also under section 10. Because of time I will try to move on to page 6.

However, a significant difficulty with the provisions listed before you is that the provisions leave too much to implication and inference. The right of conscientious objection and the protection from discrimination are not expressed and can only be achieved by a nurse after protracted legal proceedings. Nurses need better and more express protection and their employers need certainty.

Third, protection for health care professionals is consistent with the protection given to them in other free and democratic societies. Providing conscientiously objecting nurses with some form of legal protection would not be a uniquely Canadian development. Numerous other free and democratic societies have provided just such protection.

There is no legitimate reason for denying this protection to Canadian nurses and other health care workers when legislation for complete protection has long been in existence in Britain, New Zealand, Italy, France and 44 of the United States of America, most significantly in Illinois, Washington and Texas.

First of all, the one in the United Kingdom has been in effect for 21 years. The one I would like you to pay most attention to, which is most specific and, I believe, relevant for nurses, and which I would like to have initiated in this legislation is the one from the United States of America on page 8.

To date, 44 American states have enacted legislation granting special protection to conscientiously objecting nurses and other health care workers. In general, these provisions allow nurses who express an objection to assisting in abortions on religious and moral grounds to be exempted from doing so. They explicitly protect nurses who voice such objections from subsequent discrimination. Some also expressly prohibit discrimination at the hiring stage.

1450

For example, we believe the best one is the Texas legislation which provides under section 1, that "A physician, nurse, staff member, or employee of a hospital or other health care facility who objects to performing or participating, directly or indirectly, in an abortion procedure may not be required to perform or participate, directly or indirectly, in an abortion procedure."

It goes on to state what these health care professionals may do if they find their rights are being violated. It is very well expressed in this Texas legislation.

Such protection, it is suggested, should also be given to Canadian nurses. Doing so would be consistent not only with provisions enacted in other western jurisdictions but also with current Canadian moral standards as expressed in the ethical codes of various Canadian professional organizations. Protection of nurses is consistent with the ethical codes of professional organizations in the medical field such as the Canadian Nurses' Association. The code of ethics adopted by the Canadian Nurses' Association provides that a nurse is not ethically obliged to provide requested care when compliance would involve a violation of his or her moral beliefs. When that request falls within recognized forms of health care, the client should be referred to a more appropriate health care practitioner. Nurses who have

or are likely to encounter such situations are morally obligated to seek to arrange conditions of employment so that the care of the client is not jeopardized.

The code recognizes an ethical sphere within which nurses are free to act in accordance with their personal beliefs. Nurses are not obliged to remove themselves entirely from an area in which ethical concerns are likely to arise. Also, I have listed the Registered Nurses' Association of Ontario that has adopted a policy statement in 1988 on the right to refuse to participate in care. Part of that policy says:

"The primary focus in such discussions must be on the good of the patient and the obligations of the individual nurse and the health care agency to provide care.

"Despite that, whenever possible, consideration should be given to the right of the health care provider to request relief or transfer from active involvement in caring for patients undergoing a procedure which would violate the provider's religious beliefs."

Specifically, note that the transfer is simply a transfer from active involvement in caring for the patient undergoing that particular procedure. However, it leaves us to wonder why, if such codes are indeed in place, why there is no support in practice for the rights of conscientious objectors in this province. When is it all to be enforced and put to rights? Again, it is imperative that legal protection be provided through legislation.

If one might take a true example of an existing and effective code, it is that which exists within the Canadian Medical Association code of ethics for physicians. This code, I believe, explicitly provides physicians with the protection we as nurses are seeking. Paragraph 12 guarantees the physician an absolute right, except in an emergency, to refuse to accept a patient. No reasons are needed for such a refusal. It follows therefore that a refusal on moral grounds would be perfectly acceptable. In addition, paragraph 16 emphasizes that even when a physician has accepted a patient, he is not obliged to recommend a form of therapy if he is prevented from doing so by his conscience. The only duty in such a case is for the physician to tell the patient of this fact.

The Canadian Medical Association has explicitly considered the abortion issue. In a 1985 policy statement on abortion, it unequivocally stated that: "The association... supports the position that no hospital, physician or other health care worker should be compelled to participate in the provision of abortion services if it is contrary to their beliefs or wishes." This statement also includes nurses.

The Canadian Medical Association again considered the abortion issue in its 1988 policy summary. This 1988 policy statement on induced abortion states:

"A physician should not be compelled to participate in the termination of a pregnancy..."

"A physician whose moral or religious beliefs prevent him or her from recommending or performing an abortion should inform the patient of such so that she may consult another physician.

"No discrimination should be directed against doctors who do not perform or assist at induced abortions. Respect for the right of personal decision in this area must be

stressed, particularly for doctors training in obstetrics and gynaecology, and anaesthesia."

We believe these concerns apply equally to nurses.

Finally, the concern has been raised regarding the functioning of hospitals. It may be argued that the protection sought here will impair the functioning of hospitals. We do not believe this concern can be justified when it is analysed. It can be possible for employees to arrange work schedules of nurses so there is someone available on any particular shift who has no conscientious objection to abortion procedures.

Further, the administrative problems should be seen in context. In whatever area abortion procedures are performed, be it obstetric, gynaecology, operating room, day care, surgical wards, these procedures constitute a minority percentage of the cases done in these wards. It is therefore not reasonable to exclude these nurses from their trained specialty areas because they may conscientiously object to abortion procedures or to any other procedures that would deliberately end the life of any human being.

We therefore believe legislation should be introduced in the form of a regulation instituted by the minister through the auspices of the proposed Bill 43. The legislation could adopt the format used in other jurisdictions mentioned previously, thus enacting a basic prohibition against both compulsion of and discrimination against health care workers involved directly or indirectly in abortion. Should the proposal statutes be violated, the legislation should also include recommended steps to protect these individuals unequivocally. Nurses for Life strongly recommends legislation similar to that adopted by the state Legislature of Texas.

Our concern as an organization is to ensure legal protection for all as soon as possible. This has been reiterated both federally and provincially. Why is there no law yet? There is no reason. The ideology of choice must be extended to conscientious objectors here in Ontario, Canada, and not only to a select group of Canadians. It is time, ladies and gentlemen, to accord us the right of conscience and protection against discrimination. These rights are ours and we should not have to beg for them any more.

Respectfully, I thank you very much for hearing me.

Mr J. Wilson: I was just wondering, you mention Bill C-43 and that you have made representations to the federal government which is probably where the remedy you seek should be on the abortion issue. Have you made representations at the provincial level and if so, what is your response?

Ms Petrucka: This is the first presentation I have made at the provincial level, representing the group before a committee. If I may make a comment on what you are saying about the national level, they said, "Well, no, it belongs to the provincial level." So, as I say, the buck has been passed on and I figure the buck has been passed on long enough. That is why we are going to be seeking through provincial legislation that each province enact, through its own provincial Regulated Health Professions Act, regulations that would protect conscientious objectors in each of their own provinces.

Mr J. Wilson: Because the federal government felt it was a health care service.

Ms Petrucka: That is right.

Mr J. Wilson: Are there any other examples of procedures or actions that nurses may object to on religious grounds?

Ms Petrucka: They would probably have to introduce that themselves. What I am referring to specifically is abortion. We also include euthanasia procedures that we know are not recognized legally. I know for a fact that it is happening in hospitals today but it is not recognized legal procedure, so if that were to be recognized at some time in the future, we believe on moral grounds that we should have legal protection to be free from assisting in that as well.

Mr Beer: I was going to raise the issue of euthanasia as something which, while not legal to date, clearly if we just look in the recent news magazines, is an issue that we are ethically going to have to deal with. At the present time are you aware of nurses who have refused to participate in an abortion procedure? Has anyone been disciplined for that? The reason I raise that is whether you simply want to have protection in principle. Is it an immediate problem?

Ms Petrucka: Yes, it is an immediate problem. That is why we came into existence. We are seeking it not because we have just planned it now. It arose because of the problem that existed in various hospitals, not only in Ontario but across Canada.

The Chair: Thank you very much. We appreciate your coming before the committee today. If there is additional material that you think would be helpful to the committee, you can submit it in writing.

RICK GEROUX

The Chair: Rick Geroux. Welcome. You have 10 minutes for your presentation.

1500

Mr Geroux: My name is Rick Geroux. I am a 38-year-old local businessman and father of four. I have been involved in sports for most of my adult life and my interests have primarily centred around competitive power-lifting and body-building. I have competed at Ontario and Canadian levels in power-lifting and I have achieved a provincial-level judging certificate as well as coaching a number of amateur, provincial and Canadian-level body-builders.

My reasons for stating these facts are not for pride's sake but to help you as a group to understand my credibility in the sports injury field. Injuries are an unavoidable fact of life, but the diagnosis, treatment and prognosis are of great concern to any athlete at any level. My first involvement with chiropractic may have been spinal-related, but it was not long before I realized that due to the understanding of the nervous, skeletal and muscular systems, a chiropractor could be of great service to athletes in a wide variety of ways.

On one specific occasion, I damaged the tendon of my right extensor carpi ulnaris on my forearm. The medical doctor I visited diagnosed a tear of the same but gave no treatment other than long-term rest and possible surgery. Because of my respect for Dr Dean Love, a local chiropractor, I consulted him regarding the injury and with the

use of ultrasound, massage and ice to reduce inflammation and scar tissue, my arm was fine and I returned to training not only with a functional limb but an understanding of how to reduce the possibility of injury. On numerous occasions I have encouraged not only those under my training but my peers to seek the care, compassion and consultation of Dr Love with regard to wrists, knees, shoulders, ankles and any other injury related to muscle, tendon or joint.

It is my understanding that there is proposed legislation that may not provide for detailed diagnosis and management of injuries such as these by Dr Love or his colleagues. Due to the expert care that I have experience, I would consider this to be a grave mistake.

Mr Beer: It will perhaps come as no surprise to learn that a number of people have raised this particular issue. I guess the answer at the moment has been that chiropractors can treat those sorts of injuries, but the question is around the diagnosis. I simply wanted to underline that we realize this is an issue we have to come to grips with and we have had a number of examples such as the one you have given here, and we will be considering that.

Mr Geroux: The basic point that I think has to be stressed is the right to diagnosis. I listened to the lady before us. We seem to be losing so many rights. And I think we have to be careful. If I have an injury that I know can be solved easily and inexpensively through our medical system but I have to walk a different road, I think we as taxpayers not only suffer monetarily but we will suffer physically.

Mr Beer: Again, what we have to wrestle with here is the balance between the protection of the public and the consumers' right to make a free choice about the service, but it is also important that you be protected. I guess that is what we have to ensure.

The Chair: As I have told other presenters, if you think of anything that might be helpful for the committee members, please submit it in letter form or written brief to our clerk during the course of our deliberations.

PAT JOLIN

The Chair: Pat Jolin. Welcome. You have 10 minutes.

Mr Jolin: I am glad to see once again in Sault Ste Marie we have some participation from the government side, I hope our side, to the goods and bads of this thing.

My name is Pat Jolin. I live at 27 Hawthorne Avenue here in Sault Ste Marie. As some of the honourable members are well aware, I have had occasion to speak before on different priorities the government had towards injured people.

I was a licensed class-A mechanic at the time of my injury, in the heavy equipment field. I was injured in September 1977 in the company truck. The road was washed out and I was taken with it and it caused many of my injuries. I pulled myself up to try to prevent injury and I fractured and injured my shoulder and neck. It caused a lot of ongoing problems.

My subsequent experiences with the workers' compensation system were so frustrating that three years ago I helped to establish, and am president of, the Injured Workers Advocates of Sault Ste Marie, which is a very strong organization. We are nearly 500 strong. Our organization is

currently working through the Sault and Algoma as well, which takes in quite a territory.

When I got my shoulder injury in 1977, I first contacted the company physician through phone calls; I also saw one. I was told there was nothing wrong, just keep an eye on it and let it go. His diagnosis was that I just bruised it and to keep an eye on it. So I continued to have a lot of pain and problems but I kept on working and I remained working for approximately two to three months. I blacked out one day coming down the Montreal River hill. It is on 17 north, where the Edmund Fitzgerald went down. It is about a 5,000-foot drop there. My truck was halfway down the drop. So when I did come to, I was very upset and disturbed. I phoned my immediate supervisor and went into the hospital to be checked out.

The orthopaedic surgeon who saw me at that time, after numerous X-rays and about five doctors later, was Dr Fyfe and he explained what had happened. He said I had fractures in the clavicle and the AC joint and this was affecting the nerve supply to my head and it was the cause of blackouts. I had surgery to remove part of the clavicle at this time. The operation was not successful in reducing the constant pain and restricted movement of my shoulder.

Dr Fyfe then explained that the only thing further he could do was major surgery involving breaking my chest bone, and removing part of heart and my insides to operate on the damaged part of my back from the inside instead of outside. At that time, he referred me to Dr Rod Myers, who is a chiropractor here in Sault Ste Marie and who he said had a very good understanding of shoulder and neck problems and might be able to help me and save the need for further surgery.

When I had my first visit to Dr Myers I was immediately impressed by the detailed examination and understanding he had of my shoulder problems as well as my neck problems and everything else that was involved, as a whole. I brought in the hospital X-rays with me, which he studied and explained to me very explicitly, right down to detail, exactly what the problems were. After the various tests he made through the examination he explained the mechanical problems of the joints and how the various muscles and nerves and even my neck were part of the problem. He then attempted to start the motivation of chiropractic treatment on me.

He treated me with traction, manipulation of my neck and shoulder, pressure points and muscle work all around my shoulder, and electrotherapy. He has kept me functioning well ever since and I have been most grateful to have avoided surgery, because without the treatments, I cannot even walk, I cannot talk properly and lately I cannot even write. From the outset, he explained he could not cure my shoulder. There was no way he could, because of the effects of the bone injury and the surgery. His goal has been to keep me functioning and he has done such a fine job that I have recommended him to almost everybody I have met. He was recommended to me by Dr Fyfe and also my family physician. I have had nothing but compliments from them on what he has done up till this day.

1510

I am told that the suggested new law would prohibit chiropractors from diagnosing these problems in my shoulder and other non-spinal joints, as well as other people who have the same problem as myself, and it would provide that only a medical doctor could make the decision to make a complete and thorough diagnosis. This is not my experience at all, as I have just explained briefly. I do not believe in it for the simple reason that I have had some problems with doctors who do not believe in chiropractors. I will get into that a little bit later if we have time.

From the many claims I have handled with the organization that I lead, Injured Workers Advocates of Sault Ste Marie, I know that this change in the law would create a lot of extra hassles with Workers' Compensation Board claims mainly. A number of workers have been told by WCB staff that chiropractors should not be diagnosing or treating extremity joint injuries. Given my excellent experience with chiropractic, I have sorted out a lot of these problems and encouraged these workers to see chiropractors with good results. At that time, if the chiropractors cannot help them, they will advise them to go to their MD or their family physician or whoever it is.

If the law is changed to prohibit chiropractors from diagnosing non-spinal joints, the WCB consultants and staff, who are some of the doctors I just explained about who are giving us problems by verbal abuse, by being biased—these workers will lose their rights to choose chiropractic care. I even have some examples which I will get into very briefly afterwards. I cannot imagine why the government would want to do this when chiropractors usually have a more detailed understanding of medical joint injuries and produce quicker and better results. They can also save surgery and a lot of money, as in my case.

Further to this, what I have are a couple of examples of a situation. I believe you have a copy of—

The Chair: Yes, we received your written presentation.

Mr Jolin: Okay, and I believe you also received a copy of a documented proof which was in southern Ontario. I would like to bring that up, as it has also happened here in Sault Ste Marie, and in my dialogue book of representations—I average anywhere from three to sometimes five a week, sometimes many more, verbally or with the Workers' Compensation Board, as well as with the family physicians. What happens is the extremity joint problem is very ongoing. I myself have seen seven different doctors and they have said there is no way I could be helped; I have to suffer pain for the rest of my life. In turn, I went to a chiropractor, as many of my clients did, and we were relieved of our pain through temporarily solving problems with chiropractor treatments.

I had a special occurrence here just within the past two-week period of going to a special clinic in southern Ontario, which has not been funded by your government or by the WCB. They say they do not warrant it because they do not recognize some of these doctors.

The chiropractors keep me walking, talking and writing, and the doctors say there is nothing more they can do other than just give me pain pills. I am sick and tired of pills,

and I am not the only one. I have nearly 500 clients. I would not say all of them are in the same boat, but a number of them are. At my meeting, which was just this past week right here, I asked for a show of hands, and one third of the whole audience put up their hands. They cannot survive without chiropractic treatment, and the chiropractor was very observant to inform them that their problem is in their joints and in muscle-relaxing. All doctors do is give you pills and send you home to bed; you have to stay off work for a week, whereas if you take ongoing treatment, you do and you can motivate enough to keep a job, and that is our main goal, to get back to work, to be in the workforce.

Again, there are another couple of small items which are not that relevant, but I do have a couple of distinct cases that I could bring up if time permits afterwards.

The Chair: You have less than a minute.

Mr Jolin: Yes, okay. It is the rights of the workers' choice, which I believe we should have, between doctors and chiropractors. As far as I am concerned, I have had nothing but good luck with chiropractors. Doctors, there are some of them I could take them outside and run over them, because they have done more harm for me than good. I am not the only one, and I am not choosing sides, because there are beautiful doctors out there. As you know, they can do the operations and what not.

But I do have three examples of this in my care. Chiropractors can diagnose strength problems, I believe, better than doctors. Doctors do not know your life history. A chiropractor will sit down with you, listen to you and go through the whole system with you and feel it and check it out. Before he will even do anything which might cause harm or do good, he will let you know. I believe that should be kept on and the legal foundation or law which is going on here right now should not change. If anything, it should change, in my opinion, in the condition of the chiropractor.

The Chair: Thank you very much for an excellent and thoughtful presentation. We appreciate your coming before the committee today and sharing your views with us.

Mr Owens: On a point of clarification, Madam Chair: As we are having the different ministries come and speak with us during the week of the 16th, I am wondering if we could ask the parliamentary assistant and the ministry staff to get in touch with this presenter to determine the numbers of people who have been denied WCB claims because of their association with a chiropractor.

The Chair: Mr Owens, for your information, the request has already been made for the WCB itself to provide that information to the committee during those weeks, but your request is duly noted and I would say to the presenter that if you have any data, statistics or information that you think would be helpful, following Mr Owens's request, we would appreciate it if you would send it into our clerk in written form so that we may consider it during our deliberations.

Mr Jolin: I have many cases that are similar to mine and it should be noted, I do believe, by the government, because they stood behind me when I was in the Legislature many times, as you well know, representing the

injured people across Ontario and across Canada, if need be, and this is still the ongoing thing.

1520

J. DENNY WILKINSON

The Chair: J. D. Wilkinson, please come forward. You have 10 minutes for your presentation.

Mr Wilkinson: In introduction, as you may have observed quite quickly, I do have a visual disability. I will not be able to respond visually to any of your queries, so I appreciate the verbal response. Thank you.

My name is J. Denny Wilkinson. I have several positions, as you will note on the brief submitted to you. I am a registered massage therapist, I am a nutrition and health consultant, I have a doctorate in naturopathic medicine, I am an associate member of the Canadian College of Natural Healing, a certified practitioner of the European Community and a member of the International Academy of Natural Health Sciences. I have been director of the Natural Health Clinic in Sault Ste Marie for some 10 years.

I am not specifically going to read the brief, I am just going to discuss a number of points within the brief rather than attempting to read it. Primarily, the objectives are, first of all, to complement, and second, to criticize the current legislative proposal and make several recommendations for improvement of the concept and recommend some changes in interpretation of health care, that is, a look at the two models of health care, the medical model and the natural health model; and last, to recommend some development for consumer education and, of course, a look at professional education.

First of all, the compliments and critiques: Certainly high commendations are in order to all who have come to this point over the years to develop this long overdue legislative package. The inclusion of the choice factor is indeed a most important aspect. The move also to self-regulate and bring in the ecologies of the various professions is certainly extremely well accepted.

The question arises, however, about the controlled acts. The diagnostic clause has received a tremendous amount of attention, and rightly so. However, looking at the approach to colleges, and assuming that their mandate is to administrate and support their members in their work, would they not in essence develop that area, what we call controlled acts? Would they not in fact be better left in the hands of the colleges? They know their members and they know their training. They know what is required. If in fact the freedom of choice is going to be there, is the consumer not responsible for choosing the right practitioner, without a great deal of legislative-type protection? Any act is a high risk if it is performed by an untrained person.

I understand from the materials I have had access to that much of the argument is turf battles. Each individual practitioner or group of practitioners just wish to maintain a high standard for themselves, and really without much due respect. Some of the material I was reading was about the ophthalmologists not being too happy with the optometrists, the obstetrician is not happy with the midwives, the dentist is not happy with denturists and dental hygienists, etc, and it appears to me to be simply turf battles. I would

suspect there are enough consumers out there who could make a choice, and it would certainly keep everybody busy. I do not think there is any lack of business, and I get the distinct feeling that much of this controlling is for turf protection, rather than for consumer protection.

There are in essence only two models of health care practice. One is the medical model and two is the natural model. It would be well and quite worthy, I would think, as a suggestion, to look at the Quebec plan at the present time, and maybe some adaptations of the Quebec plan and maybe the acceptance of the naturopathic practitioners from Quebec and their standards. A good look at that would be quite valuable.

Education: If in fact the consumer is going to make a choice in his health care, he really needs to make an informed choice. Therefore, some education is going to be necessary. A recommendation might be that the Ministry of Health—not the professionals, although in consultation with professionals—define an educational format, an educational program for citizens so that they are aware of choices. It is very difficult to say, "You have a choice," if the average consumer is not really aware of what those choices mean.

A second major area might be, through the Ministry of Education, a development through the school curriculums. We have seen a number of times that teachers have been very biased towards various other professions, other than the medical profession. Professional education, of course, is also very important, and we do need to do some development in that area.

The natural health model appears to be one of the most important areas of development, and there are some very well-established educational facilities now available in naturopathic medicine, in homeopathy, in herbalism, etc. All these can be defined. The Canadian College of Natural Healing, the Ontario College of Naturopathic Medicine and, of course, many others are truly available, whether they are on-shore schools, that is, Canadian schools or in fact international schools, as we are finding out in our international academy, with some excellent programs.

Naturopathic doctors and medical doctors both have medical branches, but I know it has been a real difficulty in defining or trying to find an establishment of naturopaths. There is only one difference between a naturopathy doctor, respectfully submit, and a medical doctor, and that is that the naturopathy doctor does not use drugs or surgery. That is specifically part of the medical model. We are not by any means saying that one is better than the other and we feel definitively a program of co-operation is needed. Some people definitively prefer to have a medical doctor, a medical practitioner. Some people prefer to have a naturopathic practitioner. When I say naturopathic, I mean anything from the naturopathic doctor to the chiropractic, to the osteopathic, to the herbalist, homeopathy, etc. We believe in the work that we are doing through our international levels, that the consumer has to have that choice.

The naturopathic doctors and the medical doctors of whatever branch should be accepted as equals with due respect for each other. We find too many of these turf battles. The United Nations has actually declared so, that we should

be in that vein of thinking, and the Canadian College of Natural Healing up in Ottawa is Canada central for the European Community and the international community.

We are really at the dawn of a brand new understanding in health care and we are committed to assisting in the development of this kind of process where the consumer will have a full range of choices. It is hoped that these turf battles will disappear, because it is the consumer who gets locked in the middle of the turf battles. Many good practitioners are in Ontario right now in naturopathy or from the Ontario College of Naturopathic Medicine and from international schools. We have many good chiropractors, osteopaths, etc, and this program of development needs to come through.

In economic terms, finally, I would suggest that if the consumer has that freedom of choosing, is definitively choosing, much of the economic value would be very well noticed and acceptable. If a consumer prefers to have a naturopathic physician, the insurance plans would do well to respect his or her choice, and to pay either model, whichever the consumer chooses.

We are committed to developing this area of co-operation in our province of Ontario, to develop a system that we can all be proud of. Our goal is for all of us to work together, to support each other, to consult with each other, and not deal with the turf battles and who can do this and who can do that. The professionals themselves, through their colleges, know very well what they can do.

The Chair: Thank you very much for a very thoughtful presentation.

1530

ALGOMA PHYSICAL REHABILITATION CLINIC

The Chair: I call the Algoma Physical Rehabilitation Clinic. You have 20 minutes for your presentation.

Mr Salituri: Thank you. I am your last speaker. I am sure when you were all coming up to Sault Ste Marie, our good MPP Tony Martin told you how cold it can be in the Sault at the end of August. In fact, it has snowed—

The Chair: That is the last of his presentation.

Mr Salituri: I am sorry, Tony. There goes my job as his campaign manager for the next election.

It is a pleasure to have you up here in Sault Ste Marie. Usually, these processes for some reason seem to bypass us, so welcome to the Sault. Hopefully, you had some time to enjoy our area. My name is John Salituri. I am a physical therapist, and this afternoon I want to speak to you on behalf of the physical therapists who practise here in Sault Ste Marie. In fact, I am a physical therapist who practises in a private practice here, and that is what you see in your agenda, the Algoma Physical Rehabilitation Clinic. There are three other physiotherapists who practise with me there.

My purpose this afternoon is to discuss the Physiotherapy Act which is part of the regulated act. Specifically, I will convey to you our thoughts and concerns on how the present content of the act will affect physical therapists and our patients on a daily basis. The committee has already heard a submission from our provincial professional body, the Ontario Physiotherapy Association. We firmly support that

submission and now wish to add our grass-roots perspective on the issues raised by the OPA.

We are very pleased that this process has now led to a commendable legislative act. We especially support the objectives of the act, specifically the protection of the public from unqualified health providers, and confirming the right of individuals to choose and have access to the health care they deserve, including physical therapy.

This act can be improved by addressing the following three issues: First, the protection of both our titles, that is, physiotherapist/physiotherapy and physical therapist/physical therapy; second, communication to our patients of our professional opinion regarding their complaints, that is, diagnosis; and third, performing procedures below the dermis.

With respect to protection of title, I am a graduate of the faculty of medicine, University of Toronto, and my degree is in physical therapy. I will ask that you turn to appendix 1. There are several appendices I would like you to put your attention to as I go through my presentation. You will see that this is a copy of my degree, and you will see that it states quite clearly that I have a bachelor of science in physical therapy.

As outlined clearly in the OPA submission, the terms "physiotherapy" and "physical therapy" are interchangeable. In fact, the term "physical therapy" is most commonly used in the world, as well as by recognized degree-granting institutions such as the University of Toronto. As an adjunct here, I also have a licence to practise in the United States and my licence in the state of Michigan states that I have a licence to practise physical therapy.

It is understood that physiotherapy and physical therapy can and should only be performed by physiotherapists or physical therapists. In co-operation with provincial medical doctors, the procedure of physiotherapy/physical therapy has been removed from the OHIP schedule of procedures that they may bill for. This is in recognition of our exclusive right to practise physiotherapy and physical therapy.

Please refer to appendix 2 for an example of how the term "physical therapy" has been used inappropriately. This is a commercial circular that came to my attention. If you will draw your attention to the bottom quarter of the page, you will see I have highlighted for you one of the points, "Four hydro-therapy jets provide relaxation and physical therapy." I am sure we all agree that inanimate objects such as a hot tub cannot perform physical therapy, as much as a paintbrush alone cannot perform painting. The obvious point here is that only qualified health professionals can deliver part or parts of their scope of practice and, therefore, title and scope of practice must be fully delineated in this act.

In order to ensure that the objectives of the act are met, that the public not be confused about what acts or health care professionals are competent, both the titles of physiotherapy/physiotherapist and physical therapy/physical therapist must be protected by this legislation. This change then will reflect reality.

The second point that we would like to bring to your attention is diagnosis. There is an unfortunate omission in the Physiotherapy Act that does not recognize the fact that physical therapists question, examine, deliberate and form

a conclusion with every single patient that we face. We must then, by ethical standards, properly document this process and communicate our conclusion to our patients and act on it appropriately. This process is commonly termed "diagnosis." It is not the exclusive right of any health professional group to engage in this process. In fact, diagnosis is a part of good clinical practice and patients' fundamental right.

Physical therapists as primary care clinicians must continue to diagnose within our scope of practice. We do not infringe on diagnoses that are the realm of other health care providers, for example, the diagnosis of diabetes.

In our daily practice there are examples of our skill to diagnose within our scope. It is common knowledge that the majority of our patients are referred to us by physicians. Most of these referrals, however, do not provide diagnoses and we, therefore, must diagnose before deciding how to treat the patient, or if our intervention is appropriate at all. As well, it is common for physicians to request our physical therapy diagnosis so that a clearer clinical conclusion can be achieved.

If you follow me through the next few appendices, I will give you an example of what happens daily in physical therapy practices across the province.

Appendix 3 is from a circular that was created by the board of directors of physiotherapy. It was actually presented to the committee previous to this as this process was going on. I draw your attention to the right-hand side of the page, the table entitled, "Survey of Diagnoses Provided by Physicians on Referral Forms for Physiotherapy." Two clinics were involved in this survey, clinics 1 and 2, and I have highlighted the results of those. You can see that in clinic 1, specific diagnosis was only provided in 10.7% of the referrals, and in the majority of the other referrals, it was nondescript and it was perhaps just a description of the patient's complaints. Similarly, in clinic 2. The point here then is that referring physicians usually do not provide a specific referral. Therefore, it is up to us to make sure that we go through that process before treating.

Appendix 4. This is an example of referrals with no specific diagnosis, requiring physical therapists to diagnose before treating. This is the referral form we use in our office. Under the heading of "diagnosis" I have highlighted the word "back," and this is what the physician has written here, simply "back." This is what I am faced with when I see patients. So obviously I must go through the process of diagnosing before deciding what to do with this patient.

Similarly, in appendix 5, the diagnosis is low back pain. That is really not a diagnosis, that is a description. He queries here that it is discogenic, but again, we must go through the process of deciding what is wrong with this patient before we can obviously treat.

Appendix 6. Here the referring physicians are not sure of the diagnosis and our thoughts are requested. We, therefore, must provide a physical therapy diagnosis. I have circled and highlighted for you under "diagnosis," "NYD." That stands for "not yet diagnosed." I will read the whole line for you. It says, "Right flank pain not yet diagnosed, associated with back pain." Under "objectives" the last two lines read: "I have not yet X-rayed his back. If he

doesn't improve then I will X-ray." Basically, this physician is telling us: "Have a look at this fellow. See what you think. Do what you can. If you can't make him better, give me a holler. Let me know what you think and I will X-ray it or we'll investigate it." That is normal daily practice, and here is nothing wrong with that.

Appendix 7. Similarly, the physician's diagnosis, he writes: "Right leg pain. Please assess and call me to discuss." He queries here "Psoas plus or minus SI." Again, we must diagnose this patient, decide what we think the problem is, treat it and let the physician know, and together we come to a treatment plan that is appropriate.

Appendices 8 and 9. Here the referring physicians request our opinion regarding appropriate treatment for the conditions. We therefore must confirm the diagnosis before deciding if we can offer treatment. It must be made clear that diagnosis and treatment are an integral part of the same process of offering good health care to our patients.

Appendix 8. Peter is the name of one of the physiotherapists who practises with me, and the second line of the referral here is a query, "Is this beyond orthotic help?" So when Mr Kotyk looks at this patient, he has to decide whether he thinks the diagnosis is such that the treatment of orthotics is appropriate. He must obviously be a diagnostician to make that distinction.

[540]

Appendix 9: this is a referral from an orthopaedic surgeon who has highlighted in his very graphic writing, "Can you help?" Obviously, our surgeon has confidence in the fact that we can diagnose, decide what the problem is and— "Can you do something about it? If not, let me know and we will go from there."

Appendix 10: As well, the legal profession often requests our clinical opinions and diagnosis. Of course, patients consent to this and thereby also request our diagnosis as their right. Appendix 10 is an example of a legal letter that we often get in our office. Of course, accompanying this is the patient's consent, so the patient knows this is coming. Lawyers in their own way will delineate exactly what they want us to address, and you will see in the many points that this particular lawyer asks, he uses the terms "diagnostic procedures," "conclusions" and "prognosis." These are terms that one expects from somebody who is able to diagnose. Of course, if we are to give an opinion, we in fact are then diagnosing.

Appendix 11: In my practice, injured workers with workers' compensation claims make up our largest group. In the required documentation we must provide our diagnosis. Appendix 11 is a form that we must fill out on all of these appropriate patients. I have highlighted for you "WCB diagnostic codes." What that refers to—if you flip the page over—is a booklet that has all the diagnoses known to the clinical world, and they are coded. These codes are being used by several other institutions and not just the Workers' Compensation Board. So obviously, here the board is asking us for a diagnosis and asking us to flip through this book, find which one we think is appropriate, and put it in here.

So the Workers' Compensation Board, of course a reputable institution, recognizes that we, as physical therapists, can diagnose. It is evident then that we do diagnose with every

patient and it is an integral part of the delivery of appropriate health care, thereby reflecting the objectives of the act.

The procedures below the dermis is our third and last point. There is an omission in this act of procedures below the dermis, which physical therapists perform on a daily basis. The debridement of burn wounds and acupuncture are the most common examples of such procedures. We respectfully request that the act be revised to properly recognize such important procedures as being within our scope of practice.

Recently, with the friendly amendments, I understand that a procedure which we call tracheotomy or suction of the tracheotomy, which is sticking a suction tube down either someone's nose, mouth or trachea to remove mucus. That is something that came out through the friendly amendments. That is now within our scope of practice. Certainly things such as the debridement of burn wounds and acupuncture are not as invasive as something which is now recognized as within our scope.

In summary then, we are generally pleased with the act. We respectfully request that three amendments be made to ensure the act realistically depicts the practice of physical therapy thereby guaranteeing the spirit and the objectives of the act. First, protect the titles physiotherapy, physical therapy. Second, allow physical therapists to continue to communicate to our patients and pertinent others via diagnosis. Third, allow physical therapists to continue to perform procedures below the dermis. The act will then truly embody the safe and effective practice of physical therapy as it occurs daily throughout Ontario.

Thank you very much for your attention. I will be most happy to answer all of your questions.

Mr Owens: I was going to playfully ask you, as a person registered in the States, whether you thought cross-border physio was a problem, but anyway—my real live question is with respect to your concerns around diagnosis. In reviewing the samples that you provided for us, I am wondering if in fact you are not performing an assessment within your scope, providing information for the physician to draw a conclusion and make a diagnosis rather than yourself making a diagnosis?

Mr Salituri: No, we are in fact making a diagnosis within our scope of practice. This is what the physicians want. This is what they have recognized. The reason they refer them to us is because they recognize we have a specific expertise. They think this patient needs that specific expertise. Who better to decide whether that expertise is appropriate or not than us, the physical therapists? So we do diagnose within our scope of practice. We do that continually and yes, the term "assessment" is perhaps appropriate; but more appropriate we believe is the term "diagnosis." This is what we have been doing and this is what we do today.

Mr Owens: I guess I am just beginning to wonder whether we have been perhaps a little bit loose with our usage of language for a long period of time, and now that we are trying to tighten things up, we find problem areas where accepted language is not necessarily the language of the function that we are performing. Do you have any sense of that?

Mr Salituri: Yes, I agree with you. Diagnosis is within our realm of practice and it should be there. Perhaps it is not being used appropriately by other people, but certainly when it comes physical therapists, we embody that term. Again, diagnosis is a process; you just do not pick out of a hat. You assess, you question, you examine and then all of that together is diagnosis. You started your question with the term "assessment"; that is part of diagnosis. When you assess you have to come to a conclusion, if you are any type of thinking professional. There you have your diagnosis.

Mr Owens: But I think then it is how you put that conclusion into practice and what you do with that conclusion.

Mr Salituri: Exactly.

Mr Owens: Intellectually, we cannot regulate how you think, but—

Mr Hope: We can convince them.

Mr Owens: Maybe the right-wingers on the committee are the thought police.

The Chair: Actually, that did not come from the right wing.

Mr Beer: Which wing?

I would like to understand a little better how you work on a day-to-day basis with the medical profession. Just using the examples that you have provided us with—and I thank you very much; that was very helpful—having then received this and then going about trying to determine what it is that ails these individuals, what then is the ongoing relationship that you would have with the medical doctor who had originally referred these people to you? What would happen?

Mr Salituri: The process that follows then is, if appropriate and if necessary, we contact the physician after first examining the patient by phone if necessary and say—

Mr Beer: I am sorry. You might not contact the patient?

Mr Salituri: We might not if the diagnosis is very clear, if the problem is such that it is amenable to our treatment. We will certainly contact him immediately if we recognize that this referral is not appropriate, there is nothing we can do for this patient. We get back to the physician saying: "I think this is going on and if this in fact is what is going on, there is nothing I can do about it. Please act on that."

That does not happen most of the time. Most of the time the referrals are appropriate. We have excellent communication with the physicians. We communicate with them through telephone and we communicate with them certainly through discharge letters of which I do not have an example here. In that discharge letter it is very much like a physician referring to an orthopaedist or a cardiologist. We outline the examination that we made, the history of the patient, the conclusion, the diagnosis that we came to. We outline in detail the treatment and the outcome of that treatment and recommendation as to further treatment if necessary.

Mr Beer: Would you have similar contact with chiropractors at times or is this mainly with doctors?

Mr Salituri: This is mainly with physicians. I do not know about other areas in Ontario, but in the Sault we

have some referral of patients back and forth and yes, this does happen. We communicate with each other and that is part of good health care and, you know, the spirit of this act is such that no one body has rights to the total scope of health care or to decide where you should go within the realm of health care.

To do that we, as health professionals, must interact with each other. The previous gentleman talked about turbulence. He is correct in his perception, but those walls are rapidly coming down. As we all recognize, we must work together. This is one of the commendable parts of this legislation. Those of us who do not want to do it now will have to if we are to make this thing work.

The Chair: Thank you very much for your presentation. Comments? Mr Martin. I thought you would want the last word.

Mr Martin: I am not used to this. I want to thank all those who came forth to present today. When we suggested to the committee that we come to Sault Ste Marie, we knew there were folks here who had some very important things to share with us. I think it is important that this government get out to the whole province, particularly the north and Sault Ste Marie. It was good that you came forth, and I think today was a good example of government in action. I also want to thank my colleagues for deciding to come here, and to let you know how happy I was that you did and how much I enjoyed having supper with you last night.

The Chair: I am sure I am speaking on behalf of all the members of the committee, both those in the government caucus as well as those in the opposition caucuses, in saying that we have very much enjoyed the opportunity to be here in Sault Ste Marie today. We also enjoyed the hearings in Thunder Bay, in Ottawa and in London. We have had an opportunity to hear from people outside the centre of Toronto where the majority of our hearings have been held.

The committee—this is for everyone's information here—will begin clause-by-clause examination of these bills after the House reconvenes, which is September 23. We will likely be in the clause-by-clause process through the month of October.

If anyone has further information they would like to share with the committee, they should feel free to communicate with us in writing via the clerk of this committee. We very much appreciate everyone coming out today and sharing their views and observing our deliberations. I think, as I said, I speak on behalf of all the committee members; it has been a very productive use of our time. I feel the public hearings have not only been very productive but have been a very good experience for all members of this committee.

I would like to thank the staff who have come along with us both from the ministry as well as from the Legislative Assembly and look forward to the deliberations that will continue as we complete the examination of these bills. The meeting stands adjourned.

The committee adjourned at 1552.

CONTENTS

Thursday 29 August 1991

Regulated Health Professions Act, 1991, and companion legislation / Loi de 1991 sur les professions de la santé réglementées	
et les projets de loi qui l'accompagnent	S-735
Algoma Child and Youth Services	S-735
Ontario Pharmacists' Association	S-737
Algoma Home Care Program	S-740
Ontario Association of Speech-Language Pathologists and Audiologists, Algoma Chapter	S-743
Ontario Nurses' Association, Local 46	S-746
Family Services Centre	S-749
Tom Hendrie	S-751
Boyce Isbitsky	S-752
Ontario Public Service Employees Union	S-755
Nutritional Consultants Organization of Canada	S-759
Ontario Secondary School Teachers' Federation, Sudbury	S-762
Michael Hamilton	S-765
Sudbury Nurses for Life	S-767
Jack Geroux	S-770
Pat Jolin	S-770
Denny Wilkinson	S-772
Algoma Physical Rehabilitation Clinic	S-773

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Le lundi 16 septembre 1991

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent

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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 16 September 1991

The committee met at 1002 in room 228.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

ALAN SCHWARTZ

The Chair: Welcome to the standing committee on social development. I would particularly like to welcome this morning Mr Alan Schwartz. As we all know, it was 1982 when Mr Schwartz was appointed the co-ordinator of the Health Professions Legislation Review. I think we are all pleased to have him here this morning.

We have arranged for a larger room, so perhaps part of the reason not everyone is here on time is that they are finding their way up from the downstairs room. We wanted to be able to accommodate as many people as possible for the presentation this morning. Mr Schwartz is able to be with us just until noon. As we are all assembled now and all caucuses are represented, we will ask Mr Schwartz to begin with his presentation.

Mr Schwartz: Thank you very much for having me here this morning. With your permission, what I would like to do this morning is spend a few minutes doing a very broad overview of some of the responsibilities I had and some of the ways in which I approached those, and then to the extent that memory allows me, I will try to deal with your questions on many of the specific issues that I know you have been grappling with during your sessions.

As the Chair has said, this review began many years ago. Actually, as a review dealing with the issues, we began in the summer of 1983. My time dealing with the issues was almost six years. I begin by saying that this comments of itself on the complexity of the issues that are before you and is also a comment on the type of consultation that was undertaken, and in my view, required.

If I could take you back to 1983 for a moment, I want to set the stage for you, which I think is important as a perspective as you consider the issues before you. There was at that time enormous dissatisfaction with the system and a lot of clamour for change. The clamour for change came from almost every regulated and unregulated health care provider. There was clamour from consumer groups. There was clamour from hospital administrators. I dare say even the government of the day recognized that the current

legislation was almost incapable of amendment and was looking for change as well.

Virtually everybody other than, if my memory is correct, perhaps dentistry, pharmacy and medicine at that time was looking for major change of some sort. At the same time, I want to say that there was at the beginning very little co-operation or dialogue between the groups. There were deep suspicions and mistrust and almost no communication between groups. I will give you a small example.

At the very beginning of the health professions review, in one of the first documents we produced and sent out to people, we referred to almost all providers of health care as "health professionals." There was an argument over that. There was truly, in 1984, a serious debate as to whether the words "health professional" could apply to many of the participants, some of whom, under this proposal, hopefully will be regulated professions in the near future.

I tell you that because I think it is an important thing to keep in mind how basic the mistrust, the lack of communication and the suspicion between groups was. If you go back and think about that, 1984 is not so long ago. We could spend serious time debating whether it was appropriate to call some of these groups health professionals.

The review itself required a number of principles that should be paramount throughout its work, and we had those. I would like to begin this morning by telling you briefly what they were.

The main principle of the review was that the new regulatory framework would effectively advance and protect the public interest. That was the number one goal at the beginning, it was the number one goal in the middle, and it was the number one goal at the end. It had a number of different aspects to it. The public has to be protected from unqualified, incompetent and unfit health care providers to the extent possible, recognizing that it is not possible in all circumstances to protect everybody; mechanisms have to be in place to ensure, to the extent possible, the provision of high-quality care; the public should have freedom of choice within a range of safe options, and finally, there should be scope for evolution in the roles played by individual professions—and I am going to come back to that later—and flexibility in how individual professions can be utilized so that the system can operate with maximum efficiency.

Those were the cornerstones of the review from the beginning. Those cornerstones I want to contrast with a number of other things. Regulation is not to enhance professional status; regulation is not to provide the Good Housekeeping Seal of Approval on any particular profession; regulation is not to determine a pecking order between professions; regulation is not to enhance the earning power of particular professions, and regulation is not to grant monopolies. That is not the point of regulation.

It is easy to forget all that among the turf wars, the ego battles and the grabs for power that were and are going on, and will go on. That is what it is all about.

I want to spend a moment or two just talking about methodology. The process used by the review was, in my view, highly consultative. It was as consultative as it could be without absolutely grinding to a halt. Was it perfect? No, it was not, but we worked hard at hearing everybody and exchanging views to the extent views could be exchanged. I believe the vast majority of participants in the review accept that. We encouraged and sought participation throughout. I, personally, and members of my staff held hundreds and hundreds of meetings over and over again on an almost daily basis with all the players.

Again, I want to take you back to the beginning because I think there is some importance in this background. There were over 200 active participants. We had guessed when this was set up that there would be 40. Seventy-five groups originally asked to be regulated. Seventy-five individual groups identified themselves as professions which ought to be regulated.

The 200 participants held widely divergent and conflicting views. There was very little understanding of the purpose of self-regulation. There was enormous pressure to grant the kinds of things that regulation is not about, and the pressures to grant powers were largely contradictory and in my view often not in the public interest.

Partway through the review, right at the end of his tenure, my colleague Jim Fisher and I and the review team had worked out a matrix of issues that we had to deal with. The matrix contained almost 500 separate issues. Each one of those 500, if you had spoken to members of the profession at the moment, was the most important thing in the world. Each one of them had to be solved, and these 500 issues often contradicted each other in the most direct ways possible.

Without patting myself on the back, but actually patting the participants on the back, I want to say that I believe it is a tremendous achievement to have gotten to where we are today, that we have achieved remarkable consensus, which in my view is also mostly as a result of the movement by health care providers in Ontario.

There was never any doubt in my mind that each issue was going to be solved, but I never believed then, nor do I believe today, that it was possible or necessary to solve every issue to everyone's satisfaction. To try to do so, in my view, is a mistake because you cannot be all things to all people in something as complex as this. Furthermore, what satisfies one often has exactly the opposite impact on another. The goal throughout in dealing with all of these issues was to have a system in place that would better serve the public.

1010

The question is, how did we get to where we are today? The answer is the obvious: hard work, patience, fairness, but most important, sticking to principle and remembering the principles we began with. Ultimately, in my view, the vast majority of participants recognized that the resolution of differences was essential and that the public-interest aspect of the process was neither for sale, for barter nor for loan. That is an important thing as well.

Most learned a great deal as the process went on, and I think again it is a compliment to the review participants how views evolved over the process and how far they came. Many groups modified their views, made their views more sophisticated and learned to better understand the purpose of regulation. It is a credit to most of them that this ended up with a successful set of recommendations.

Not every detail of the recommendations is perfect, but having said that, I believe there was a minimum compromise from principle. It never will be perfect, and to seek it to be perfect is an error, because you will lock yourself into a mental framework which will not allow you to do anything.

Having said that, it is not to suggest that a minority of participants did not dig in their heels and fight for their narrow interest right to the end, because some did, or that, since the end of the review's tenure or my tenure, some have not attempted a final grab, because some have. Is that inappropriate? Probably not.

Ultimately I think you all understand that the responsibility of the professional association is to fight for the association and to fight for what is appropriate for the association. I actually look at that and accept it as part of our process, but that was not my responsibility. My responsibility, and I believe your responsibility, was to look at it as part of the whole. Very often what groups and individuals said to you in isolation is sensible, but it is not sensible as part of a whole. It does not help the balance. It dislodges carefully thought out balances that are crucial for us to make this work.

Now I am going to just spend a few minutes talking about the legal and procedural provisions and a few minutes talking about the scope of practice, and then I will stop and answer your questions as best I can.

As you know, the legal and procedural provisions ended up with a uniform act for all. Today when you look at it, to tell you how far we have come, I think most people believe that is the ultimate in reason. It was a concept that was fought. Many of the things you take for granted today were fought, some of them more bitterly than others, but the idea of a uniform code was fought because it did away with the concept of a pecking order and people did not like that. Some people who thought the pecking order ought to be done away with actually believed that it should only be done away with to the extent that they should be brought to the top of it, and others should be left at the bottom of it.

Even something as simple as this uniform code, where the public would have the same rights and remedies in relation to all professions, where you could facilitate amendments and where you did not confer differing status on professions, something as simple as that was a matter of controversy.

All I really want to say in my opening remarks about the legal and procedural provisions is that in my view in the broad sense, and we could talk about the detail if you wish, they increase the accountability of the professions to the Legislature and to the public in a major way. Public protection is enhanced by them in a major way over what is currently the law in this province, and the formulation of public policy can be advanced in a major way by the creation of

the health professionals regulation advisory committee, or whatever it is you now call it.

The other thing I want to say about the legal and procedural part is that no system works unless it is perceived to be fair. You must protect the individual rights of the professional as well as the public, and it is this balance which is often so difficult to come to.

Individual cases or examples make it very easy to lose sight of the principle, but if you lose sight of the principle, the threat to the system is real and constant. I urge you, when you deal with this matter, to remember the importance of balancing the right of the professional against that of the public. The rule of law requires this delicate balance between the powers you are going to give to governing bodies on the one hand, and the rights of its members, and you should not fall prey to an issue of the moment to wipe out legitimate rights of the professional.

This is an analogy from left field, but you do not need a lot of Donald Marshalls to remind you of the dangers of smug and self-righteous rushes to convictions. I just urge you to keep that in mind. Our system has always protected the individual, and I urge you to remember to do that and not to get caught away in one particular instance.

Now I am going to turn a little bit to scope of practice. The scope of practice area is always the most controversial. It is not a surprise. Currently, in my view, the system grants unnecessarily wide and ill-defined monopolies. Monopolies are not in the public interest in this area unless absolutely required. Monopolies are to the advantage of the profession that holds them. It gives them economic clout and it gives them status clout, but it is often difficult to justify those monopolies in the public interest.

1020

Obviously some regulation of scope is needed since we all know that some activities pose a serious risk of harm if performed by unqualified persons. Nobody argues with that general principle, and therefore controlled acts are needed, but my view is that controlled acts should not be lightly granted. They should be granted when the evidence is overwhelming that they are required, when the evidence is strong that it is in the public interest to have them, because it is equally true that some health care services are not intrinsically dangerous. Everything is dangerous. Walking across Bay and Queen where I work is dangerous. There is danger in everything, but common sense and balance is what you are being asked to apply here.

The public should have broad freedom to choose their care giver of choice in these circumstances. Hospital administrators should have the ability to use the facilities and the providers at their disposal in ways that are most efficient for the system without undue monopolies getting in their way.

I want to spend a moment or two on the current model to put this again in some perspective. Four of the five professions currently regulated by the Health Disciplines Act are licensed under the current system, for whatever that means. In theory, and I underline the word "theory," they have exclusive licence or monopoly over the entire provision of service within their scope. Only nurses do not have that. For example, only a physician who is duly licensed by the College of Physicians and Surgeons of Ontario can

lawfully practise medicine in Ontario. Now what the hell does that mean? Medicine is not defined. The court cases are very few and far between, and in fact the one people always drag out I think happened in 1905. What did it say? It said the practice of medicine is what doctors do. It is everything. So when the CPSO takes somebody to court, it must show that the activity falls within the scope of the practice of medicine.

We know that lots of things doctors do are not exclusively licensed to doctors. The reality of the system and the theory of the system are very different. The reality of the system is that the theory is not applied in the strict sense because otherwise many activities would be halted, would be stopped, but common sense does not allow that.

All other currently regulated professions, in my view, have no clear licensure. They may tell you they do. They may show you the words in acts like the Drugless Practitioners Act to say they do, but it is very unclear that they have it. It is a miracle the system continues. They go forward and do what they do every day and are not harassed every five minutes, and if they are harassed, it actually works its way out and then they are not harassed again.

I want to remind you that controlled acts are sought very often for status and for economic benefit. That is not the responsibility of a regulatory system. The responsibility of the regulatory system is first and foremost to protect the public, to ensure the public that you are doing the best you can to ensure they get qualified help from people who can help them, and that they can distinguish as much as they can between the kind of health care providers they are choosing. As I often said during the review, after that they will vote with their feet. They will go to whom they want to go to. That is the most you can do.

Is this system perfection? Far from it. Is it an improvement over the current system? In my view it is a significant improvement, and if you pass it, this will be the most progressive regulatory system in the world. Will it allow for the evolution of health care? Absolutely, in a way that perhaps no other system can. Can you ask it to do more than that? Probably not. Can it do everything for everybody? Absolutely not.

Thank you very much, and let's hear what you have to ask me.

The Chair: After so many years of work, we appreciate your 20-minute presentation and know that it really is just the beginning of the discussion that we are going to have this morning.

Mr Beer: I think everybody on this committee is very much aware of what you must have gone through during all those years. I know I am speaking on behalf of everybody in saying that we are full of admiration that anyone could have taken that time and come up with something that even with the number of issues that have been brought before us, I think still has incredible support from the wide range of professions as being something that is positive and that we want to move forward on in terms of the public policy of the health care system.

I wonder if I could take you back to your thinking around what has been called the harm clause, which is not,

as you know, in the bill before us. What is your sense of the importance of that clause? How do you relate it to the controlled act of diagnosis? Do you think it is preferable to have either that clause or one like it? What are the things we should be measuring in the balance as we look at that particular issue?

Mr Schwartz: The harm clause, in my view, was intended to be an important safety net. It is an important safety net because I think we have done an exceptional job in looking at what should be controlled acts. We have identified, as best anybody under the process could, what the appropriate controlled acts are.

One thing I am certain of is that the list is not perfect, although I think it is pretty good. Having said that, I think that the harm clause, if viewed from the public perspective, is on balance an important safety net. It adds another layer of protection that I think on balance the public is better off having. Its relationship to diagnosis is important as well. If you remove the harm clause, my advice is do not touch the diagnosis clause even a little bit, because you will then be weakening this from the public's perspective in a way that I think is unjustified.

Ultimately people who come before you are, because of how the process works, the providers of some service. The less restriction they have to do whatever it is they do, the less they have around them in terms of responsibility to the public, the better off they are. It is safer for them. But it is not them we are ultimately seeking to protect. We want to be fair to them but to protect the public.

In summary, I think the system does not fall apart if the harm clause is removed. Having said that, I believe the public is served in a significantly better way if it is kept in in some form. If it is removed and you tamper with the diagnosis clause, it appears to me that you are now removing layers of protection from the public that are impossible to justify.

1030

Mr Beer: At the present time, the harm clause is not in the legislation and you are saying that if that is so, then be careful with the definition of "diagnosis."

Mr Schwartz: And I am urging you to put it back in.

Mr Beer: Right. Now the other term that is linked in is "assessment," and many people who do not have one of the controlled acts, or not as many as they would like, have suggested that the term "assessment" does not allow them in effect to do some of the things they have been doing or that "diagnosis" would provide that. As you wrestled with those terms, "diagnosis" and "assessment," is there a definition of "assessment" that might help if it were in, in terms of what people could do, or how do you see that distinction between those two terms?

Mr Schwartz: Let me just add one thing to the harm clause thing. It is easier to take it out, and I do not mean that in a facetious way. When you are looking at this kind of legislation, if you take it out, you satisfy a whole large group of people, and there is nobody in the actual public, whom it is going to protect, saying, "Son of a gun, I am better off with it." So the easy thing is to remove it. The more difficult thing is to keep it in. If you keep it in and it is going to do all these terrible things that people say it will

do, which I do not accept at all—I fundamentally believe they are misinformed—the package is done in a way where you can take it out in two or three years. If you do not put it in, there will be tragedy before you start thinking about putting it in, and it will be tougher to put it in than to take it out. So I just want to leave you with that thought on the harm clause, that in a sense, taking it out is the easy thing to do.

Now, diagnosis and assessment. My first comment is I do not believe it is useful or necessary to define "assessment" in the act. There are a number of different reasons for it and a number of different ways of looking at it. Currently there is a licence to practise medicine. I know that does not mean taking my temperature in the morning or telling my child, "You have a cold," but I do believe that if push comes to shove, it does mean "diagnosis" as it would be defined by a court looking at the facts.

Having said that, I think there is an important distinction between "diagnosis" and "assessment," although I understand that the words in the generic sense are used interchangeably. We are not discussing this broad level. I am aware that many groups are saying to you, and said to me, "If there is 'diagnosis' in there, we cannot do what we are doing today." I do not accept it. I think they are mistaken. I do not believe there is anything to say that they are right, but this is one of those arguments we could have for ever. They will say: "We don't believe them. We think it will happen the other way." The only way you will actually know is when it is in place and working.

I want to ask you to do the following: Imagine, if you will, that you are here as a committee and the problem before you is that we want to give an exclusive licence to the practice of medicine today. Everybody in Ontario would be lined up for 5,000 miles saying: "I do part of that. The system will collapse. We couldn't go on. We assess. We diagnose. We do all those things." Somehow, miraculously, it has not stopped them. The system goes forward and works.

I believe that when it comes to it, the courts, as they almost always do, will come to a commonsense meaning within the parameters of this entire bit of legislation, understanding how health care is delivered, and give a definition for "diagnosis" that will suit a particular case in a meaningful way. They will understand that every single day people look at you and say, "You have a sore shoulder and I am going to treat it," and that this is not the diagnosis, because it does not get down to the different layers of underlying cause that are myriad in a full diagnosis, that this is the difference and health care providers are doing just fine without it.

Some health care providers such as medical doctors require it, because they do it, but not everybody does do it, and while everybody wants to say they do it, because it makes them feel good, they do not. It is not your responsibility and it certainly was not mine to make them feel good. It is our responsibility to make the system work in a meaningful way for the public. They will, in my view, be able to carry on, and the argument that they cannot is either misinformed or in many cases mischievous, as people look to take a final grab. That is natural. Everybody wants

an extra piece of the pie if he can have it and what better form to have it than this.

So what can I say? For years this was the big issue. Everybody wanted as much as he could have, and I do not blame people for that. I am not critical of them for it, but I urge you not to allow the interests of particular professions to make you lose sight of the whole. By the way, the moment you start to give diagnosis in little increments to other groups, there will be a lineup of new ones who say: "Wait a minute. If you gave it to them, the principle has been eroded, and I ought to have it because what I do is not so far different from the next group." Then you will end up providing diagnosis in 35 different ways and you truly will block the system. You will block its evolution, you will block its ability to work and you will block the co-operation that I believe the system will put in place.

Mr J. Wilson: Mr Schwartz, thank you on behalf of our caucus for your years of hard work. We certainly appreciate your comments concerning the controlled act of diagnosis. This morning you have been able to expand on some of the things, although we have obviously heard some of the comments from legislative counsel, but you did say in your remarks that physicians, for instance, need the diagnostic act, the controlled act, because they do it. Certainly, there is no argument there, but it seems to me that in the course of these hearings we had groups—speech-language pathologists come to mind—telling the committee that they have spent several years, more years than a physician, for example, learning their trade and learning what they say is diagnosis. They want the ability to communicate that diagnosis to their patients. So I am just going to ask you to continue with this, although you have said a great deal about it.

I understand from legislative counsel that there is a worry that if we start tinkering with this controlled act and giving it to other groups, as it were, there would be some sort of domino effect. Do you want to expand on that for another minute or so?

Mr Schwartz: First, let me start with speech-language as a specific one. Speech-language people are highly trained. They are well trained in what they do. They are highly qualified at what they do. They have an important role in the system. None of that says they diagnose, none of it, because it does not matter how many years you went to school. Going to school is important in terms of what it teaches you. Physiotherapists go to school for a long time and are highly qualified and play an important role in the system. When you go to a physiotherapist—so I take the pressure off the speech-language people—you go with something that is supposed to be a prescription, and it says, "Sore left shoulder, stiff right knee." So I guess the physiotherapist can say: "Well, the doctor just told me there is a sore left shoulder. It is up to me to diagnose what it really is."

What these people are trained to do, eminently trained to do, and should be encouraged to do, is to treat symptoms, and they can do so, but diagnosis goes to a level which is different. It goes to root cause, and root cause is often exceptionally complicated. Layer upon layer has to be stripped away until one is certain of root cause, and

while sometimes you know root cause because it is self-evident, it is not always so.

1040

If you took a group like speech-language and provided them with this diagnosis, which I begin by saying they do not require to do exactly what they are doing today—that is my first principle; they do not need it—but if you give it to them, believe me, what you are going to have, just to pick on another, is why should you not give it to the physiotherapist? Then if you give it to the physiotherapist, let me go down the list and tell you, you are going to give it to everybody. I do not believe that is either necessary or in the public interest. What it will do, by the way, is it will make the speech-language people very happy. They will be delighted. They will think you are a nice man. They will think the legislative process works perfectly.

Mr J. Wilson: That would not bother me at all.

Mr Schwartz: Right. I understand. The issue, though, is whether it really is needed, whether it is better for the system and whether it is in the public good. My view on that is no, no and no.

Mr J. Wilson: Just to play devil's advocate again, I certainly understand the points you have made, but there are a number of people who would say, "There's an economic argument here and it is better for the system not to have to refer someone to a physician." For instance, audiologists make what they tell us is a diagnosis. They tell us they would not be able to communicate that diagnosis to their patients, which they say they are doing now, but instead would have to communicate it to the family physician. The person would have to go back to the physician to hear the news and then back to the audiologist for treatment. Now there is certainly a perception out there from group after group that this is what the new system would be.

Mr Schwartz: It is a perception of convenience. There is not the slightest evidence that this is so for most of these groups. It is a perception, and if it is a perception, you cannot deal with it with words, because the only thing that will solve the perception will be for the system to be in place and to work the way I believe it will work. Then they will see it is not so. There are no words I could say today that will provide comfort to people who want to say: "I don't believe that. It'll work differently." I accept that. It is one of these arguments that you could discuss for the next five years without coming to a conclusion. You either have to believe it will work one way or work the other. I, for one, do not believe that it will work the way people are saying it will work.

I also believe that most of them understand that, but some of them truly do not. But most of them do, and this is an argument about getting more status, more economic power and a so-called more important place in the system. None of that should concern you. In fact, I urge you to throw that out in your thinking, because it is absolutely the last thing that is important. What we want to have in place is a system of delivery within the regulatory framework that is as flexible as can be while protecting the public to the extent that is feasible.

Believe me when I tell you that the way the system is drafted, if these people are right, the fixing of it will be easy. If you go the other way, taking away what you give them now, if they are wrong, it will be much tougher. If you give into what they want and grant it to them, it is like all the time. Taking away what people have is pretty tough, and you will not do it because legislatures do not. If you go the other way and they turn out to be right, which I do not think they will, you will be able to fix it relatively easily. The system is not perfect. I said that at the beginning and I accept it, and there will be some glitches. The glitches will fix themselves.

Having said that, these are policy decisions you have to make. What will better serve the public? My view is that what will better serve the public is to go ahead, and if they are right you can fix it easily. If I was right and you go with their solution, you will have hurt the public in a way that you will not be able to easily change, and that is the tradeoff you have to think about.

Mr Martin: I would like to continue to some degree on that same vein, except to put my question into some context. You have referred to one piece of it already. To start off with, at one point in time, medicine was seen as that which doctors do. I think anybody who has had anything to do with the medical profession over the last few years will agree that medicine is changing more quickly and that the understanding of health care is broader now than it ever was before and that who actually participates in that scope of activity is up to question. With that in mind, there is the evolution of our understanding and not understanding how medicine is delivered and who participates in that process. I come from northern Ontario where professionals are not always readily available to do the kinds of things they are asked to do, perhaps solely, under this legislation and I am speaking maybe for some of the members who live in rural Ontario.

When you did your study and proposed what you did—I accept the principles under which all of that has been presented—did you consider the needs of remote areas of northern Ontario and the need for diagnosis quicker than that which could happen if only a certain class of people could do that, and the transportation difficulties that are up there and in rural Ontario where access to certain professions is not always that readily available, or was this piece of legislation designed simply to accommodate the ever-burgeoning Golden Horseshoe challenge of providing medical care? I will leave it with that, and then we deal with a supplementary.

Mr Schwartz: Let me start and try to come at it in a number of ways. First, I think we considered rural and northern Ontario every day of the week and thought about delivery issues every day of the week. So to the extent that you are assured by my saying that, let me begin by saying it because it is a fact.

Second, saying that somebody can diagnose does not mean they can't in rural Ontario or anywhere else. What is of more concern for northern Ontario and for rural Ontario is to be able to ensure that people can do and follow certain treatments under certain circumstances where others

are not available. That is a legitimate concern that should be addressed to the extent legislation can address it.

Having said that, you cannot magically say, "Because there is nobody there who legally can diagnose, let's say somebody else can diagnose." It is different. I want to differentiate these issues. But having said that, I want to come back to the principle which says that to the extent we can recognize that rural and northern Ontario require treatment to be delivered sometimes by people you would not think are the first line to deliver that treatment, I am sympathetic. I believe the legislation should be as flexible as it can be to allow that to happen without consequence befalling those who are put in a position of providing the treatment.

Mr Martin: What I might hear you saying is that because people are limited to treatment, they may never get to diagnosis because it is not within their scope and because there is no convenient access to the professional we may for ever continue to do treatment.

I cannot help it. It just keeps running through my mind. A while back I had a problem with my car in that my starter kept breaking. The mechanic I was bringing it to kept putting in new ones and they just kept breaking. Eventually I got to a mechanic who told me there was a little glitch in the flywheel, the starter, that broke it all the time so we needed to fix that. I just have the fear that if we do not allow folks a greater scope in some of the remote areas to do diagnosis, they will continue to simply do treatment and people will not get helped.

1050

Mr Schwartz: Let me try to deal with that. Let me start with what I said earlier, which is you cannot say, "You can diagnose," and therefore you can. What the system does try to do to address the issue you have just raised is to allow health care providers to evolve in ways that are required by the system and ways that are encouraged by the educational programs in Ontario and otherwise. So if people's skill levels generally—let's not focus just on diagnosis—or the needs of consumers change, the system is evolutionary enough to take that into account which, by the way, the current system is not.

If people learn to do diagnosis, if providers learn to do diagnosis who currently cannot do it, I suspect they will go before the advisory council that is in place and make a case that they now have a kind of diagnostic ability that they may not have had four, eight or 12 years ago, and it will be granted, but it will be granted because they will show that they actually have the ability to do so rather than because there is a perceived need for somebody who has that ability to be there. Because there is a perceived need for somebody in a certain town to have diagnostic ability, it is not sufficient to say, "I designate you as the person who has it." You actually require somebody with that ability to do it.

Hopefully the system will evolve, not only through the regulatory system but through other mechanisms, so that no part of Ontario is left without people with the ability to diagnose ailments. I do not know if that is the case in parts of Ontario today, but if it is, it should not be. You cannot solve it by simply saying, "I'm going to give a legislative right to somebody else to diagnose." That does not solve

the problem. It does not deal with the problem. The problem has to be dealt with, I am afraid, in other ways. I come back to my first response which says that is also different from allowing people to treat.

Mr Martin: I have another supplementary from my initial comment. Understanding of the delivery of health and health care issues is expanding as we speak. I have noticed more problems today in the area of mental health than ever before, yet we have more professionals out there than ever before. Regarding the harm clause you suggest we put back in, I have a concern that those who would participate in the realm of mental health as semiprofessionals, perhaps connected with churches or social organizations, may in fact back off from doing that good work. A community needs to heal itself, and often those kinds of people who simply have goodwill and want to participate will back off and not participate.

I use an example in my own life, of people who used to drive young people to ball games, tournaments and camping and who stopped doing that because of the sue-me attitude that developed in communities. If you get into a car accident, you could be paying for the rest of your life, so you decide: "We're not going to do that. Forget it." A lot of really good programs that used to take place in communities that were very mental health oriented, took care of kids, have stopped happening because people were afraid they would be sued. They do not do it any more unless they have hugely expensive insurance policies in place.

Again, I look at northern Ontario and rural Ontario where we do not have the kinds of opportunities to do things that they have in the larger centres. People will back off from being involved in the whole area of caring for people in the self-help type of operations that often are the best thing that is happening around mental health in a community. That harm clause will impact there.

Mr Schwartz: First of all, your concern is a legitimate one. Let me make it clear that the harm clause was not intended to, and in my view would not, impact on that. But let me come back to it in a minute and expand. The harm clause is not intended to stop pastors and social workers and people like them from doing what they do every day in communities in northern Ontario, in rural Ontario and in downtown Toronto. It was never what it was focused on. In fact, I would be horrified if it stopped them from doing it, because I think it would be wrong. Having said that, I do not believe it will stop them. I do not believe courts will find them liable for things under it.

If your concern is that there may be some wording that can be found that can be added to the harm clause that specifically takes away that concern, I do not know, but I would be more comfortable leaving the harm clause in because I think its benefits to the public are important ones in finding a way around that problem.

These are discussions which cannot easily be resolved. Social workers and clergy come in and say: "We believe we will be stopped. We have been told that is so." My response is I do not believe they will be stopped, and I am telling you they will not be. What kind of a discussion is this? You cannot come, in a way, to an intelligent solution

based on one side saying, "We think it's going to happen this way," and another side saying, "We think it's going to happen that way."

Having said that, I bring you back to my earlier comment, which is that I think the overall impact of taking out the harm clause is bad for the public. At the same time, I am very sympathetic to what you say about social workers, clergy and others. While I do not believe there will be any harm done to them, to use a bit of a pun, having said that, it does seem to me that there may be some legislative words that can be found that make that clear. I would be more comfortable with that solution than what I consider the simplistic solution of just taking the harm clause out. It is always easier to do that, because you do not have the examples of what it is going to do to protect the public at large in front of you. Those examples will come and grow with the system functioning. It is always easier not to focus on it and to say: "Let's take it out. It must be bad." But simplicity, unfortunately, is not always the best route.

I can only sum it up by saying I am sympathetic. I think you are right. The legislation was not intended to stop those activities. I for one do not believe it will. If you are so nervous about it, find a way of coping with it, but do not strip away protections that the public will otherwise have the benefit of to deal with that problem. That is my bottom-line advice.

Mrs McLeod: I would like to continue with an element of that same theme because it is obviously a central concern for the committee, but I ask you to focus less on the issue of extension of diagnosis and more on the concerns we have heard that with the dropping of the assessment clause, the one you had recommended in the report, the ability to communicate an assessment seems to have disappeared where communication is not specifically included in the definition of "controlled act." That is quite different from the issue that some groups have with an extension of diagnosis.

Mr Schwartz: I should be up here telling you that if they took out what I wrote, it must be a disaster, but it is not so. There are a number of things on which, in my view, you could go one way or another and the whole system does not change as a result of it, and this is one of them. I put assessment in because I thought it ought to be in, but I am not uncomfortable with it out. I do not believe the impact that people have described around it will in fact take place. I cannot say anything more than I do not believe it.

It is not logical, because courts are, after all, creatures of logic and understanding of how systems work. When a judge who has actually been through the health care system once or twice looks at the totality of what is going on, there is no way he is going to imagine that the legislation is intended to curtail people from saying: "You've got a sore right shoulder and I think I should manipulate it. You've got a bad whatever it is and I think I ought to do this." Common sense tells you that is not what is intended and that is not what is going to happen.

1100

Would I be happier with the assessment clause in? I guess the answer is by a little bit, because I had it in. But

after that, I just do not think so. People are overreactive. They are overreactive in some cases because of genuine fear of the unknown and in some cases, dare I say, for political and strategic reasons. So people are overreactive to a lot of this.

As I said in my opening remarks, imagine what would be going on if we were here and my recommendation had been: "We'll have one monopoly. It will be the practice of medicine." What the hell does that mean? Nobody could do anything and it would be inconceivable to us today to do that. Yet that is the system, in a sense, and it works. This system will work and people will not be stopped from communicating these things that they are communicating every day.

Mrs McLeod: Let me ask another question then, something very specific that has been raised, I think, with some compelling arguments by a number of the groups, and that is the issue of title protection. I know the basic premise—at least I understand the basic premise—you brought to the legislation was that it be as simple as possible in terms of the issue of title protection. But we have heard a case, for example, from a speech-language pathologist that the term "speech therapy" is common usage and that not to protect the title of "speech therapy" would create confusion in people's minds and would in many ways subvert the intent of the legislation. I think we have heard similar arguments from—

Mr Schwartz: Psychologists, no doubt.

Mrs McLeod: Psychologists with psychological services, physiotherapists and physical therapy are the three that come to mind. I wonder if you would comment on whether or not there is not a valid argument being presented by those groups.

Mr Schwartz: I take exactly diametrically the opposite approach, and let me just take one minute and tell you why.

First, I think the most important thing about title protection is that it help the public. So how is it going to help the public? It has to help the public by allowing them to identify health care providers in different ways. If you protect a few titles, a simpler number, over time the public—give them some credit—will figure out that regulated speech pathologists have this title and other people do not, because for the next five years they will use that title and only they will use it. People will actually start making the association. So first, fewer titles makes the possibility of making the connection better. That is my first point.

My second point is that many people want generic protections of words because they will give them economic monopolies. Let's take a small example. I can give you many, but I do not want to get too far down the line on this. What is the importance of the word "psychological?" Here is the importance of it. You will have a school giving some broad psychological test and the next thing you know they will say: "Wait a minute. You cannot do that. That is mine. You need a psychologist to do it and if it is not a psychologist, you have to stop."

Title protection is another thing that is there for the protection of the public. It is not to grant wider monopolies to people. It is not to give people economic status. It is not

to give people status in their community. The more narrowly you define those words, the clearer they will become to the public over time. The confusion today is for the other reason, that you have all these words floating around the same professions. They are used by others outside the profession.

My view is quite different than theirs and I believe that in many cases the economic motive is high on the list of reasons. So I am sorry, but I cannot agree with you of some of the groups. These are not new arguments to me.

The Chair: Thank you, Mr Schwartz. The request from Hansard is that you just speak into the microphone.

Mr Schwartz: Sorry Hansard, wherever you are.

Mr Jackson: Alan, it is good to see you again. I have three brief questions. The first one has to do with sonography and ultrasound, if you can share with the committee why it is not necessarily identified in or necessarily identified out. Can you speak to us about that issue?

Mr Schwartz: Yes. When I get down to very specific things like that, I am going a bit from old memory, but I do remember, from looking at the ultrasound issue very carefully, that there is not the slightest evidence in my view that there is any risk of harm at this moment in ultrasound that requires a controlled act, particularly given the settings in which these things take place and all the realities around it. But it was not there. It is not a controlled act because for me the evidence was not compelling enough to make it a controlled act. I want to say for ultrasound that my memory tells me it was not even close.

Mr Jackson: Just a minor supplementary then: It has come to my attention, and maybe members of the committee, that this argument aside, there is the notion that there are people operating ultrasound services in this province without the supervision of necessarily qualified persons. To the extent this practice is occurring, would that in and of itself not be grounds for reviewing that decision?

Mr Schwartz: No. You can find abuse of anything. It does not mean you have to put in place a complex, integrated regulatory system to deal with it. If you find those kinds of abuses, if they are real and if they are doing damage, there are other ways of dealing with it and I suggest that those ways be looked at first.

You do not want to, in a sense, cheapen the regulatory framework or try to make it deal with every single possibility. It cannot, it should not and it should not be asked to. There are lots of little things that go on, other players, some other situations, that might require some other kinds of regulations, some other kind of law passed, but it does not mean that they all have to be part of the regulatory framework that we are talking about. I think it would be a mistake to do it that way.

Mr Jackson: My second question has to do with presentations we received from the native community with respect to its unique status. As a lawyer, you will appreciate the evolution of their right to recognition of their customs, laws, etc. That is occurring from a legislative perspective, but it does not appear to have occurred in tandem with your review and this legislation. It surfaced in several areas and you are probably aware of those areas in which it surfaced. However, as to the cornerstones of your

legislation, which are to protect the public, provide choices and not to confer status or benefit, it strikes me that native requests before this committee almost stand alone as not having been addressed from that perspective.

Mr Schwartz: Let me begin by saying you are correct. They were not addressed from that perspective. The native concerns may be valid. I have not examined them. I have personal views on native rights that are not relevant in a sense. Hearing said all that, it is no reason to stop. It does seem to me that whatever agreements native groups in Ontario work out with the government of Ontario in relation to their own status and their right to, if you will, opt out of existing systems and have their own, will be unaffected by this. If the agreement allows them to opt out of this totally or in part, it should do so as part of a comprehensive understanding of the native issue and not in a piecemeal way.

I for one believe it is a mistake to wait until that works its way out. There is no reason to believe this is a particular impediment that is any lesser or greater than a million other impediments before them, or that it will require any particular hardship to deal with. I do not think it will. That does not for a moment suggest that I do not think they ought to be able to opt out or do anything else, but I do not believe it is a reason to stop, because if you stop for that, there will be something else to stop for.

1110

Mr Jackson: I do not believe I was suggesting we should even consider that. The question is one rather of concern as to who, if anyone, is studying or considering the issue or listening in this matter. You can advise the committee if in fact this matter was specifically told to be exclusive of your review and report.

Mr Schwartz: The answer to that is, it was not. But the other side of the coin is that it was not an issue we looked into in any detail, because we were not asked to by anyone, including the native groups, we did not deal with it.

Mr Jackson: All right, I will leave that. My final question has to do with—

The Chair: What I am trying to do, Mr Jackson, to be fair, is to divide the time available equally between the caucuses in the numbers of questions that are asked. Could you make this your last question?

Mr Jackson: Is it the number of questions or the time?

The Chair: Both.

Mr Jackson: Good. Then my final question has to do with the practice of chiropractic. There were compelling arguments made, predominantly from semiprofessional and professional athletes, around this sensitive issue of diagnostic extension to chiropractic beyond the vertebrae. Again, it strikes me that these were issues that dealt with protecting the public and providing for choices. Can you share with the committee for the record, publicly, what your concerns were? We are familiar with what you have recommended and you are familiar with what the response has been, but these presentations, which I found most compelling, are from the public and not necessarily from the chiropractors themselves.

Mr Schwartz: I would say that in relation to chiropractic, at the time I did the review, I did not believe there was compelling evidence to suggest that they can do diagnosis, for simplicity for the moment, of the extremities. I still do not believe that. This is different than a discussion of what they are very capable of treating. They are exceptionally capable of treating many joint-related ailments. I think they do it well. I think they do it in a way that benefits the public, and I think the public has lots of choice about going to them and do go to them.

On the other hand, my current view is that giving the right of diagnosis to chiropractors in relation to these particular areas should not be based on the evidence of athletes. The evidence of athletes is that they were treated and that the treatment worked, not that there was a diagnosis of underlying ailment. You do not know that, because there is a difference between the treatment and diagnosis. Moreover, I go back to the issue I raised earlier. I remind you that chiropractors are covered by OHIP in Ontario. These arguments often have economic implications that are crucial. I believe this is one of them.

The issue before you is whether you want—and this is the beginning of it—the chiropractor to become the GP of tomorrow. Maybe you do. I do not know that. But there is no doubt in my mind that chiropractors are well-organized. They have a very clear agenda and are moving towards it. I do not fault them for that. The real question for me is whether I believed the evidence was there, and my response is that it was not.

I am certain, by the way, that athletes are well treated by chiropractors. I respect what they do. I think they make an important contribution and have an important place in the system. Those are different arguments than suggesting that this means they can diagnose to the extent they say they can. They do not, by the way—well, I will just leave it at that. I just do not accept the argument.

Mr Hope: One of the areas I would like to focus on is the controlled act dealing with attendant care and social workers. I was listening to some of your comments where you were saying the diagnosis is getting to the root of something. A lot of social workers get to the root of a problem through stripping away, through consultation and through dialogue with the patient. I am trying to get an understanding around attendant care, first of all, giving these people the ability to live independently, using attendant care to help in their everyday living. Social workers do get to the root of the problem. That is where I am trying to put the two. First of all, it would be around attendant care. Section 26 does stop them, does it not?

Mr Schwartz: The question is, stop them from what? I need more information.

Mr Hope: Performing the daily contributions to living for a disabled person.

Mr Schwartz: All I can say in this discussion is I disagree with that totally. We are into a question of what is it a court will do. I do not believe that is what was intended. I do not believe that is what the legislation will do. I know there are people who have come in here and said that is what it will do, but I do not accept that. I think it is incorrect. It

is easy enough to say that is what it will do because since it has not been passed and is not in place, there is no way to say you are mistaken, other than to say you are mistaken.

Your premise that it will stop attendants from doing these things is not one I accept. I said earlier that I do not believe that any of the legislation, as it is drafted, will stop social workers from doing what it is they do. I do not believe it will stop them. They will be able to continue. They make valuable contributions to our society. This is not intended to stop them, and it will not.

Mr Hope: But if I am understanding you right, you are saying you will leave it to the legal process, which is the court system, where they use common sense. I guess we could talk about that commonsense approach, but when you are dealing with the general public and their approach to the social worker, do we try through an experimental process where we put people as victims?

Mr Schwartz: Sir, I do not want to be argumentative with you, but it is quite the contrary. This is not using people as victims. I think if you reflect on the legislation as a whole, you would not say that too easily. It is quite the contrary.

You have to be specific if you want to talk about people as victims and say exactly how it is going to happen. You could go back to my opening remarks. Today the practice of medicine is licensed. You could say, "Well, this makes people victims," helping social workers do what they are doing. Somehow they manage, and they will manage under this system. While you could have an academic argument about the perfection of courts, let me put it to you that there is no perfection in wording. You will never find perfect wording. You will never find wording that allows everything to happen exactly as it should. To try is folly because if you try you are sure to make serious mistakes, and each time you try to do it, you are opening up a Pandora's box that has 20 new issues related to it.

While I do not want to be glib with you, I think it is too much of a leap of faith to suggest that groups will be stopped. As I said earlier, if it turns out three years from now that there is a mistake in the wording that has stopped one or two of them, it will be easy to fix. If you go the other way, it will not be.

It is always easy when there is something new coming out. I do not know what it is. It is new. It is legislation. It is a bunch of words. You can say anything you want about it, because there is no ability to point to reality and say it will not happen. Because it is not in place, the criticism that this will happen or that will happen can be made by anybody about any aspect of it, and it is. That does not of itself make it sufficient reason to do something.

1120

The Chair: If I could interrupt for a moment. With the consent of the committee—we have now been through all caucuses twice—would members try now to keep it to one question as we rotate through the caucuses so that we will maximize the fairness in time allocation.

Mr Beer: We do not get supplementaries any more.

On the question of the title of "doctor" in the bill, it sets out five who can use the title. We have had a number of people who have said, "If I've earned a doctorate, I

should be able to use that title." I wonder if you could share with us the reasoning behind the proposal we have before us and whether you see ways that could be changed. What was your thinking? I think the fundamental point has been people saying: "Look, I worked hard for many years and arrived at a doctorate. Why can't I call myself a doctor?"

Mr Schwartz: Earlier we talked about title and a number of times I have referred to the most important part which is the public, so title protection falls, as I said earlier this morning, into this category of what is best for the public. What is best for the public is to have easy ways of distinguishing and differentiating whom they are getting service from. Once they distinguish and differentiate, they can go to, within reason, whom they wish, but the information package is important.

If you put the initials PhD behind your name under the provision of health care, most people in the public, which is all I am concerned with, will understand how well trained you are and how many years you went to university. If you put "doctor" in front of your name, there is likely to be confusion as to what that means in relation to the provision of health care. I go back to my principle that I said earlier, which is that fewer titles are better, generally. Having said that, there are a number of professions which already have the title. Medical doctors are the obvious ones and that is what people in the delivery of health care think of, whether it is right or wrong, when they hear the word "doctor."

When we looked at it, we said, "There is at least one profession that has it currently that you can't rationalize in a logical way," and so to try not to take away what already existed, we extended it to include chiropractors because they get a diploma which gives it to them. Is that drawn in stone? I would say no, but if I erred in this area I would take it away from one or two groups rather than extend it.

I think extending the title "doctor" is a mistake. I think it does not serve the public well, while it does serve the egos of many others well. If I made an error, I erred in giving it too widely, so that in your deliberations if you said, "We want to change the use of the word 'doctor' that has been conferred through the review," I would do so by narrowing it, because I believe that will serve the public better.

The excuse that says, "We have been well-trained and we have our PhDs and we are doctors in other circumstances," is all very well and good. People understand what PhD means. Use it. Say, "Jim Smith, PhD," or, "Joan Brown, PhD." People understand from this that you are well-trained and have this higher degree and this higher level of learning.

If you say "Dr Smith" in the provision of health care, it is confusing to people and unnecessary and unimportant except for ego. If you want to call yourself doctor in another setting, good luck to you.

Mrs Witmer: There has been a request made by the registered nursing assistants to have their own college. Every other province has a college for these individuals. I would like to know what the reasons were for not following through on this request.

Mr Schwartz: This is a slightly more complex issue. You tell me every other province does and perhaps they do. I am uncertain of that. I know some provinces do, but the genesis of this is quite different in those provinces and the parallels are not always as even.

My view in looking at the request of nursing assistants to have a separate college was that they did not meet the criteria. I believed it then; I believe it now. I do not believe it is in the public interest for them to have their own college at this time. That is not to suggest that I do not think they should ever have it, but I do not believe it is in the public interest for them to have it at this time.

The argument is made passionately by the Ontario Association of Registered Nursing Assistants. OARNA represents a relatively small number of the registered nursing assistants in Ontario. It is somewhere around 10% or 12% of them. They do not have universal support, even within their own membership, and on balance, I do not believe it is in the public interest to do it.

I think the current system where they are part of the College of Nurses of Ontario reflects reality and better protects the public. It may be that some time in the future that will change, and the mechanisms are in place for it to change if it becomes appropriate. I think it would be a serious error at this point to give them their own college.

Mrs Witmer: Just as a follow-up, you indicate they do not meet the criteria, and I guess I would be interested in knowing what you feel the appropriate criteria are.

Mr Schwartz: I do not remember them all, but if you look in the report, they were listed. There were four of them. We looked at them all, and they failed on some and they passed on some, if you will. I do not remember the specifics. You have to remember, this was one of many decisions and it was made four and a half or four years ago, but I remember clearly my sense that they did not meet the criteria at the time. Nothing I saw until the end of my time in the review changed my mind about that. I would be very surprised if something significant has changed since then. I am sorry I cannot be more helpful. That is what I said earlier. There are details I would not want to get into without running back to mounds of notes.

Ms Haeck: Thank you very much for this opportunity. There has definitely been discussion either by the presenters or the various professional groups coming to our offices making a point that they feel—not in all instances, and there are at least two that very quickly come to mind—their scope of practice is not reflected in the current proposed bills. You have given some comments with regard to chiropractic. What are your feelings regarding optometrists?

Mr Schwartz: That was predictable. Optometry and chiropractic were two of the professions that throughout the review pressed for expansion of their scope of practice. Without disrespect to either of them, it was my view and continues to be that whatever concession would have been made, there would have been a request for a further expansion.

On the part of optometry, there is no question that there are times where the request becomes, "We're medical doctors." At other times the request is a different one, and it was a moving request, if you will. I believe that for optometry,

while it is not perfect, it is close to what they actually do, not what they wish to do, not what their counterparts in other jurisdictions may be doing, not what they think they will be doing in three years, but what they actually do. Are the words around optometry perfect? That would be one where I would say they are not and one could spend a little bit of time making it more precise.

Ms Haeck: Just because we have had presentations around the words "refractive" or "optic" or "ophthalmological" or like that: any comments on those three?

1130

Mr Schwartz: I do not because I would have to sit down and look at it in a way that I have not done for a number of years. On the one hand, I am saying on that particular issue that I could see some movement, but I urge you not to allow the movement to be a hidden way of making them medical doctors, which they are not. They are highly trained people who do an important thing, and that thing should be reflected. Their scope may evolve and in fact may have evolved in some other jurisdictions, but that is not a good enough reason. If it evolves to somewhere else tomorrow, they will have the ability under these proposals to make that argument there.

I guess my bottom line for them is that I think there is some room for movement, but I urge you to be cautious in the movement to ensure it does not suggest a scope broader than the reality.

Mr Waters: I managed to sit in on some of the other hearings. I am a bit concerned.

The Chair: I am sorry, Mr Waters; in rotation, I apologize, Ms McLeod is next.

Mrs McLeod: I wanted to raise the issue of hearing aid prescription and access to the service, which is another of the concerns that has been raised with the committee. It seems quite clear in the legislation following your report that prescription can be done by both physicians and audiologists, so the audiologist does not need to be involved in every prescription of a hearing aid. Is that your understanding as well?

Mr Schwartz: Correct.

Mrs McLeod: Did you deal with the question of concern for access with limited numbers of audiologists, or was it your sense that physician to hearing aid dispenser was sufficient to deal with the question of access?

Mr Schwartz: It was both. I think physician to hearing aid dispenser is sufficient. I think audiologist to hearing aid dispenser is sufficient. But I do not believe it requires the audiologist. So my answer, to be clear, is both. Access is an issue and that alone may have been enough reason to do it, but I believe it for both reasons.

Mr J. Wilson: We had appear before this committee the College of Physicians and Surgeons Task Force on Sexual Abuse of Patients and one of its requests or recommendations was to include in this legislation wording such as a doctor convicted of sexual abuse should automatically lose or should therefore lose his ability to practise medicine. I was wondering whether you feel that type of amendment would be appropriate in the Medicine Act in the scope of

this legislation. It opened up a whole area we are very sympathetic with.

Mr Schwartz: I am not as current as I am sure you are on the sexual assault report. What I know is what I know from the newspapers, I am afraid. My understanding was that the report had not been finalized, and I may be wrong about that. I would not make any amendment, first, until there had been a final report.

Mr J. Wilson: Just to help you on that, how about if I told you that we are almost certain this will be one of the chief recommendations of the final report?

Mr Schwartz: Second, I would say it is my understanding—and I stand to be corrected on this because it is just from the newspapers—that this is a report which is certainly legitimate enough in dealing with an exceptionally important public policy issue that used a different methodology than, for example, the health professions review. I am unclear how widely this report has consulted.

Without thinking about sexual abuse, this is something I referred to in my opening remarks. Sexual abuse is a horror and has to be stopped. Having said that, I believe that issues as important as the horror of sexual abuse require broad consultation so that you do not go swinging down the road of too easily removing the rights of various individuals. I do not know whether this report is doing that. But having said that, when the report comes out in its final form with that as a recommendation in a context of some sort, which I am unaware of, I suspect that will be the subject of some spirited public debate, as well it ought to be, because these are fundamental freedoms we are discussing.

Having said all that, I want to make it clear, that sexual assault is a horror that has to be dealt with clearly and has to be dealt with as precisely as the system can. I cannot comment on whether I think that is a good amendment or not because I do not know enough and I have not seen the final report. I do not understand the context very well. I do not understand at what point this will happen. I just do not know enough about it.

These are the kinds of amendments, however, that can be brought in quite easily after you have had the required public debate. I think you owe it to the system to have it. In a funny way, it cheapens it to do it too quickly. These are exceptionally important issues that require your thought. It requires the input of a broad range of individuals. That may be what this report has done. I just do not know enough, so I do not feel comfortable telling you that this is a great idea or a bad one.

Mr J. Wilson: I appreciate that.

Mr Waters: As I started to say before, I have some concern. After sitting in on some of this, what I get the feeling of, and actually in a lot of discussion in my riding what we seem to get the feeling of, is that doctors are now going to have more rights than they had before and have a better stranglehold, that instead of opening the system up, everybody has to report to the doctor and have very specific permission to do anything with the diagnosis.

I will give you an example. A doctor might take 100 hours' training and another person in a certain field might spend four to five years training on that particular thing.

Yet the doctor has the right to diagnose and the other person who has spent four years of his life versus 100 hours does not. I would like you to reassure me of your feelings and how you arrived at that.

Mr Schwartz: First, let me start by saying this is not a contest. I do not see this as sort of being in a bazaar in Morocco where we are trading off this for that. I never viewed this as a contest between doctors having more or less than they had before and I think it is an inappropriate way to approach it. In dealing with it in the generic sense, as you have, my response is that what are now controlled acts for the medical profession, in my view, is less than they had before. I think the evidence of that is overwhelming. It is not more; it is less. I believe it is significantly less. I believe that almost everybody who looks at the system carefully and reflects on it understands that it opens the system up in a number of important ways. People come to your constituency office and say, "No, it doesn't." All I can say is I disagree with them. It does.

This question of people being trained for hundreds of hours was true before. It will be true again. It does not deal with ability to diagnose. It deals with other things because the ability to diagnose is much broader than the specific training being given to people to deal with certain types of ailments or certain types of disorders. It is a different ability that requires different training and different information bases.

As I said earlier, it is like me looking and saying: "I notice you are limping. I was playing touch football with you last weekend, and I saw you trip and land on your knee. You've got a bad knee, so I think what you ought to do is rest it and stretch it." Did I just diagnose you? Of course I did not. But I might say, "I think you ought to go to any one of a number of health care providers who are trained, in some instances better than doctors, to do the actual work on the knee." It is different. They are trained to provide that service and they are trained very well, but their ability to tell you in each instance the root cause of the sore knee differs widely and unfortunately, only a very limited number of people can do that. The current system, let me make it clear to you, protects that right, and if it did not, you would be taking away a tremendous protection from the public, and in doing that I think you are acceding to special interests in a way that is wholly unjustified.

1140

Mr Beer: I realize time is passing and there are many questions we have. I am trying desperately to think how I can link the public participation on the councils to whether nurses need to have the authority of particular people to do things.

Mr Schwartz: I can answer both, now that you have said it.

Mr Beer: Now that the question is out, perhaps you can weave both in as you answer.

Mr Schwartz: Sure.

Mr Beer: One of the key questions here is public participation in the councils and how that will work. We have had a number of different approaches: that a third of the membership should be from the public; something just less than 49%; the College of Physicians and Surgeons of Ontario

suggested 40%. As you look at how those councils ought to work and the balance between professional people and laypeople on them, what should we be directed by in trying to determine this? Maybe there is not a balance; maybe all you can say is it is between a third and 49%.

Mr Schwartz: I think that is not a bad answer. Let me start by saying that as long as it is under 49%, I do not have the slightest difficulty with it whatsoever, so if the number is 49% members of the public, I think it is appropriate.

Should it be a third, should it be 40%, should it be 49%? None of those numbers are magic and, given the makeup of various colleges, I could see it differing slightly from college to college, depending on what the individual makeup is. You might end up with a minimum base of X and a maximum of 49%. I think that would be a common-sense solution to this kind of issue. It may very well be, for example, that for the College of Physicians and Surgeons, when you actually look at it, 40% works just because of the physical makeup and the numbers and the other balances, and that for another the number turns out mathematically to be 45%. I do not think you should get hung up on those differences. I think it is a mistake. I am comfortable anywhere in that range and think you should leave it to the individual mechanism of each college to find a solution.

The principle of increasing the public's involvement in the colleges is the important one. I think there appears to be general agreement with that, at least among the committee and on the political side, and while that may not have been accepted wholeheartedly by all the colleges earlier, it is now accepted as a reality. Once you have accepted that reality, there is no magic to any number and I would not allow that to become a stumbling block.

The Chair: Question, Mrs Witmer.

Mr Schwartz: I did not get to tell you about controlled acts for nurses, I know.

The Chair: Did I cut you off? I am sorry. Do you want to finish? Go ahead.

Mr J. Wilson: It is a separate topic.

Mr Schwartz: It is a separate topic, you are quite right, but he did a wonderful job of trying to connect it. Controlled acts for nurses: I believe there have to be controlled acts for nurses. I believe you cannot give nurses the power to do those controlled acts without some regulatory mechanism around it. The mechanism chosen by the review was one sort. I believe other sorts can work as well. The important thing to recognize, it seems to me, in relation to that is that there must be a mechanism that is clear so that nurses cannot run whole hog down the line, doing all of these things, without clear rules and understandings of the circumstances under which they can, and who it is who can from among the nursing profession.

This is one area where I would say the review came up with one method of doing it. It seemed most logical at the time, but I could understand doing it, for example, by regulation, if the regulation is carefully drafted. By the way, I know people think I am too tough on some items. I hope people notice there have been a few where I have said it could work another way. It is okay.

Mr J. Wilson: We are taking meticulous notes here, so keep that in mind, Alan.

A number of professions appeared before the committee and expressed the concern that the powers of the minister under the proposed acts are too onerous, and that where the language of the act requires colleges to do certain things, if they are not done, the minister within a prescribed time period will go ahead and do them anyway through the Lieutenant Governor in Council. I was just wondering if you had any comments there. Certainly the overriding concern was that perhaps with the minister's omnibus powers here, it is undermining the principle of self-government.

Mr Schwartz: That is theoretically correct, but "undermining" is a strong word, because what we are continually looking for are balances. I believe in the ability of these professions to regulate themselves quite a bit. I believe in the public interest being paramount and I believe each one of these colleges will, most of the time, understand their public responsibilities.

Having said that, there is a balance. The balance ultimately is that the elected Legislature and the minister are responsible. If there is a clash of wills over the public interest, ultimately it is government that decides in these kinds of issues. There are potential situations where I could see a minister being required to "require."

Let me make it as straightforward as I can to you. One would hope it never happens. One would hope that if it does happen, it is so much the exception that everybody stands up and takes notice for the next five years. I believe that will be the reality. But I think ministers in government require a stick sometimes and for those sometimes I think it is worth while.

The principle that these colleges will act in the public interest is paramount. I think they will, but I would not take away the minister's right to "require." I know it was a matter of some controversy. It is the reason why in my particular run at the words it began with a "request," not a "requirement," because I think the use of those words is an important symbol of the co-operation and dialogue between the minister and the colleges and the same role they share in protecting the public interest. So I chose those words to reflect that while in a strict sense it has no legal nicety to it, it has another nicety to it that I thought was an important one, and it was to try to address the very balance that we have talked about. I think those words are now gone, but I am not sure.

Mr J. Wilson: Yes, they are. It is clearly "require," and groups have come and asked us to go with your recommendation of "request." It particularly comes down to the complaint process, where people are worried that ministers may pursue a complaint beyond that which the college itself is comfortable with.

1150

Mr Schwartz: This is one where again I do not think the world turns on it and I do not want to pretend it does, but I do think leaving the "request" phrase in is helpful to the balance of the overall system and recognizes the responsibility, the good sense, and the public spiritedness, if you will, of the college system.

Mr Martin: I was going to ask a question around that subject too, but I think it has been answered, so I will chase the diagnosis clause business again a little bit further and suggest to you that I do not think that what we have here is a bazaar. You suggested earlier to my colleague that when we get into the issue of who can diagnose and who cannot, we may have a bazaar-type atmosphere and that in some instances it may affect the delivery of health services.

You said in your opening comments that under legal and procedural provisions, it did away with the concept of the pecking order. But if we look at delivery of health services as trying to get to the root of the cause of disease, away from simply treatment, then to place the ability to diagnose in the hands of a few versus, as my colleague said, those who have had many years of training in a particular area I think creates the pecking order again. And it takes away from some communities that do not have some of these professionals in great numbers to do the job they are doing now and perhaps could do in even more creative ways.

Mr Schwartz: I have been misunderstood if you believe what I said was that it is either desirable or required to have diagnosis in each and every instance. It is neither desirable nor required. It is not necessary to diagnose—

Mr Martin: I am suggesting to you that maybe it is. If you want to get to the bottom of why your knee keeps popping out, maybe there is something else that you need to know about your being, or if there is something wrong with your ear for ever, perhaps we should be getting at the root cause of that.

Mr Schwartz: Ultimately you are right, if it continues to be a problem that goes on and on. I suggest that if it is a problem that goes on and on, you work your way through the system till you get a diagnosis that is appropriate. Having said that, the reality is that most things do not require it and do not get it, and for those the system handles it just perfectly here, and almost in every other jurisdiction that I am aware of. So to start with, you might say a diagnosis is, "I want to have a world where everybody is diagnosed for everything." It is not going to happen and saying people have the right to diagnose does not make it so.

The reality of the system is that most things can be treated based on, to use the words we were using earlier, an assessment of what the problem is: "I've got a sore shoulder." Diagnosis is only required by exception, and whether you are in northern Ontario or in a rural community, if the treatment does not work, ultimately you work your way through the system to a place where there is diagnosis. But just saying, "Whoops, because I would like to have one ultimately, I am going to give this person the right to do it," does not mean they can. That is the difference. I do not want you for a moment to believe that in this jurisdiction or in any other jurisdiction in Canada, the United States or western Europe that I am aware of, people who have some sort of ailment get diagnosed each time in the sense of the word we are discussing here. They do not. You do not have to.

Mrs McLeod: The advisory council has been referred to a number of times, and clearly it is going to have a significant role on an ongoing basis. I would like you to add any comments you might make about the clarity of the role

the advisory council has, its structure, the way it can be used most effectively or any concerns you might want to flag.

Mr Schwartz: The advisory council is something, I am sure, you did not spend all summer talking about, because it is not in the interest of groups that are coming here asking for more to talk about it. The advisory council, in my view, is a unique part of a unique package. The package itself, the way it is structured, allows for evolution and change, legislative change.

The advisory council is a perfect public forum, as perfect as one can get, by the way, in public forums. It will have lots of its own headaches, but it is a public forum to carry that through. So many of these groups that are here before you saying, "Oh goodness, in a year or two we are going to need this or that," or, "If we do not have this it will be a disaster," know very well that unlike the current system, or for that matter any other system I am familiar with, they will be able to go with very specific cases before this body and have a very specific conversation, where others will be able to participate and give evidence or do whatever is required so that there is a true dialogue based on the facts, not based on supposition, not based on general comments, not based on people saying, "I am sure that is what is going to happen."

I am sure they will then come with the reality of what has happened. The advisory council will listen to all those realities, and within the context of the overall framework of what is going on will make recommendations. All of that will happen publicly. It is unique and I think it is excellent. Now, is the advisory council perfect? Probably not. Will it get bogged down? I am sure it will at times. If it does, you might find ways of improving it. I cannot think of any offhand. I do not think it is important enough to worry about it. What is more important is the principle that it exists and will be capable of dealing with some of the problems we have talked about today.

It is curious that during the review, many of the groups that have come before you clamouring for more were clamouring for the advisory council and how important it is, but now that they have it, it does not exist, because its very existence it seems to me weakens the need for them to have it all yesterday. They do not need it.

The Chair: What I am proposing is that Ms Witmer ask her question, Ms Haec ask her question, and then we ask Mr Schwartz if there is anything he would like to say in summary to the committee. Please keep your questions very short.

Mr Schwartz: I am desperately thinking of a summary now.

Mrs Witmer: Just briefly, there is some concern by the Ontario Nurses' Association that the management, research and teaching nurses are presently not covered by the act and that for purposes of discipline this could be a problem. What is your feeling?

Mr Schwartz: My instinctive response to this is smart aleck. Do not worry about it. I do not think everything that is being presented to you as a problem in the delivery of health care and the protection of the public in the delivery of health care is one. There are many other issues and

many other reasons to regulate people, but all we care about is the delivery of health care services by providers to the public. That is what this is meant to focus on, that is what this is meant to deal with and that is what it does deal with. I do not think it is a big deal.

I know when I get up I will be pummelled by two of the nurses or something, but on the other hand, I think they recognize how far this review has gone in recognizing the legitimacy of their role in the system. It has come 100 miles.

You cannot address every little issue to everybody's satisfaction, and I believe this is a little issue.

1200

Ms Haeck: I want to visit the dentist and denturist issue. It is before lunch, but we do not have any of the slides we have had given to us at times. The comment has been made by the dentists that denturists are really not in a position of diagnosing or of being able to assess a problem prior to the preparation of a partial plate. Would you please comment on your feelings?

Mr Schwartz: I did not follow these hearings at all. One of the few things I was told about the hearings was the slides you had to sit through, so I think I sympathize. Those slides and that argument is a major red herring. Talk about sort of emotional blackmail. Let's go back to first principles for a moment.

The dental profession has said throughout the review and continues to say: "Denturists can't do partials. It is very dangerous. If they do it, it will harm the public": Position 1 unwavering. Position 2: "By the way, those bad guys shouldn't be regulated because they're not serious about regulation and they do thousands of illegal partials." They are both compelling arguments. So the review said: "Okay, they're doing thousands and they're very dangerous. Give me three specifics. Bring me three human beings." I saw none. I suggest you probably saw none. It is a contradiction in terms.

I am not the first person to visit this issue. As you probably all know, what now must seem 100 years ago, Professor Dickens spent a year on it and came to the same conclusion I did: Let them do partials; the world will not come to an end; more choice for people and all that good stuff. But the government of the day did not go forward; it did another study because the dental group feels so strongly about it.

My first comment is there is not compelling evidence that these thousands of illegal partials that have been done have caused terrible harm. In fact, I would say there is no evidence. Now let me come to the slides. Anybody who is shown a slide of a cancerous mouth, number one, feels sick, and number two, says, "Oh, goodness, I'd better stop this." Is that not a natural reaction? Let me ask you something. What if the person with the cancerous mouth went to the same denturist for a full denture? Is it okay? If they would not notice it for the partial, I guess they would notice it when they went for the full.

These are silly arguments. These are arguments that are not to be taken seriously but are put forward seriously because these are turf battles that are honestly felt, with economic consequence. The example of this, believe me, is an example that can be carried further to many of the other turf battles you are facing. There were hundreds of such

battles. You are left with the leftovers. My view, I hope, this morning was that many of them are without merit, but you can hire consultants and you can hire lobbyists to fight it to the end, because that is the system. That does not mean you should acquiesce to them, because your responsibility is to weigh it in the context of the totality of what is being done. Looking at it from those eyes in most instances in the totality of what is being done, the system will do fine without you granting these extra powers to people who want them.

The Chair: Thank you very much. With the consent of the committee—you have had an opportunity to give us some opening remarks and you have answered questions—as I thank you for appearing, we thought it might be helpful if you would like to say anything in summing up after almost a decade from the beginning of your work. Certainly the few hours we have had this morning do not do justice to the volumes and the rooms full of material, nor, I would say on behalf of all the committee members, to the month-long hearings we have held. I do not think anyone here would begin to suggest that all the questions could be answered in this brief session this morning.

I hope that you will feel, if there is additional information you would like to share with committee members, that you can do so in writing through our clerk. I would ask if you would like to take a few minutes if there is anything further you think the committee should hear before we adjourn.

Mr Schwartz: First, the obvious is to thank you for having me. I think it is a fact that you cannot summarize in a morning except in the broadest strokes what took place over a period of six years of exceptionally intensive thought involving these issues. In a way, when I look at you, I guess I do not envy you the task of picking up the pieces in a sense in a matter of months, particularly where the system we operate under means that what you tend to get are the outlying issues, if you will.

Having said that, all I can say this morning is that I have, throughout this, not been a health professional and frankly not cared about the status and the economic wellbeing, if you will, of those who participated. I hope when you think about it and deliberate on your report, you will take the same perspective. I also hope you will think about it as a whole and not in little bits and not try and solve little wee problems in ways that will have detrimental impacts to the whole.

The system, I believe strongly, will work. The system will benefit the people of Ontario in many ways. Tampering with it too much will ensure its failure, so I urge you not to. I urge you not to be taken in by arguments that cannot be shown to be right except by people's earnest thoughts, but to go with what you have with the knowledge that it is a flexible enough system that it will be changed over time. It will evolve much like the delivery of health care is evolving.

One of you said medical doctors see their role differently than they did a few years ago, and I think that is true and to their credit. Five years from now the system will look somewhat different than it looks today. This is a moving train, but legislation is a moment in time. Do not try to catch every single car at every station, but have faith that if you put in place an overall system that has some sense to

it, it will be able to evolve with the system, because that is what it is meant to be.

The Chair: Thank you very much for appearing before the standing committee on social development. We all appreciate your taking the time to share your thoughts and insights with us. I hope all members who have witnessed

before the committee and those who are here this morning will agree with me that it has been a very valuable morning for all those who have taken the time to be here to hear you.

The committee recessed at 1208.

AFTERNOON SITTING

The committee resumed at 1405.

ONTARIO NATIVE AFFAIRS SECRETARIAT

The Chair: We have a presentation from the Ontario native affairs secretariat. I would ask that you begin by introducing yourselves to the committee. Thank you very much for coming today.

Mr Krasnick: You are very welcome, Madam Chair. My name is Mark Krasnick. I am the secretary of the Ontario native affairs secretariat. I am joined by Shelley Spiegel, who is a senior policy adviser with the secretariat.

I would like to begin by summarizing the question as it was relayed to me, which was that we were asked to discuss the issue of native self-government in relation to the regulation of health care professionals. That will be the subject matter of my presentation. I want to begin by referencing three different documents that have been approved by Ontario over the last six years. The first document is entitled the Ontario Native Affairs Corporate Policy, which was approved in October 1985. It talks about the policy which ministries must follow in the development of policies respecting the provision of programs and services to native people. It makes some points which I think are instructive to our discussions today.

First is that with respect to the provision of services, ministries are encouraged to provide specific services to meet the needs of native people and support the protection of their cultures. Second, to the extent that provincial programs or services apply or may continue to apply to native people, those programs and services should emphasize initiatives supportive of native self-determination and self-reliance and should be developed in consultation with native people. So the main operative aspects of the corporate policy dealt with cultural sensitivity in the development of programs by the province of Ontario.

There is another aspect to the policy which talked about the negotiation of aboriginal self-government, and that was amplified in late 1989 by the second document I want to talk about—there will be copies of these available to the clerk—which is the provincial self-government guidelines. Again, I think two points should be emphasized. First, one of the things that Ontario pointed out would be an objective that would guide self-government negotiations was the achievement of compatibility between aboriginal and provincial regulatory regimes. In so doing, the province was prepared to look at three different instances of self-government: One was with respect to reserve communities, the second was with respect to communities that were what we define as crown land communities and the third was with respect to urban communities, urban centres.

I think the most important aspect with respect to this discussion on self-government is really with respect to the on-reserve communities. What we say in guideline 12 is, "Ontario is willing to participate in negotiations directed towards the establishment of Indian-specific governing institutions which may exercise executive and legislative powers for the purposes of administering the reserve,

regulating the behaviour of residents of the reserve and providing services to residents of the reserve." So with respect to on-reserve communities, we were prepared to look at the negotiation of and the establishment of institutions which had legislative powers.

With respect to crown land communities, we talked about bylaw-making powers and administrative powers, and we left the question of legislative powers for another day. The main point to emphasize with respect to the negotiation of specific self-government arrangements was the distinction between the urban community on the one hand and the reserve community on the other hand.

Finally, I want to talk a bit about the statement of political relationship which was entered into in August of this year. The operative principle, I think, in this case is principle 3, and this says, "First nations in Ontario," and then it says, "involving the government of Canada, where appropriate, are committed to facilitate the further articulation, the exercise and the implementation of the inherent right to self-government within the Canadian constitutional framework by respecting existing treaty relationships and by using such means as a treaty-making process, constitutional and legislative reform and agreements acceptable to the first nations and Ontario."

The statement of political relationship has at least two underlying premises, one of which is the articulation of a government-to-government relationship between first nations and the government of Ontario. But second, it is an attempt to provide jurisdictional room to allow for first nations regulation to exist. It is an agreement which is premised on dealing with self-governing nations, and the question of what is a self-governing nation is one that still has to be defined within the first nations of Ontario and within the government of Ontario.

It finally leaves us with the question of the relationship and involvement of the government of Canada where we are looking at establishing specific agreements with respect to reserves, which is always something we have to consider. Its applicability in this case, especially with respect to the legislation on midwives, is that this may be a first intrusion of provincial regulatory power into an activity which is otherwise unregulated. As such, it puts an onus on the province to ensure that the appropriate level of consultation, discussion and agreement has been reached before the legislation becomes applicable to the appropriate self-governing nations.

That, Madam Chair, is my presentation, and I would be pleased to take questions.

Mr J. Wilson: Just in response, you raised the question of midwives. Did you answer what the natives' concern was when they appeared before this committee?

Mr Krasnick: I think what I was asked to focus on in my remarks was the relationship with self-government. The answer I was going to provide is that the appropriate form of self-government is really something which will come from the first nations themselves as their process of consultation comes to an end. At this point, it is really just in midstream. So it is very hard to come up with a conclusion.

They are in the process of coming up with the answers to some of these questions.

I think the important point is that self-government power, which is seen as being inherent to aboriginal people, is really a power which is relevant to self-governing nations, which are entities of probably well beyond single communities and probably the responsibility of groups of communities, whether by treaty area or by nations like the Iroquois or the Ojibway nation, etc.

Mr J. Wilson: Certainly the impression I got from the presentation of the representatives of the Union of Ontario Indians who appeared before us was that they felt, particularly in the area of midwifery, they wanted a specific answer, whether there would be any jurisdictional questions or whether traditional healers would be able to continue to practise midwifery and whether they would be required to become part of the College of Midwives of Ontario. If so, they would like a separate college, because they took Bob Rae literally on his statement when he said, "In all matters henceforth we will respect native self-government."

I certainly argued a long time that I do not know what it means exactly, and you said that they are working that out now. That was the concern I think the committee was presented with to some degree anyway, but you are saying that as far as the native affairs secretariat is concerned, you would not have any comment past what you have said now, because these things are being worked out.

Mr Krasnick: These things are the subject matter of a process of consultation. I would also make the point that there is a difference between the self-governing nation, which is the subject matter of the statement of political relationship, and that is that there is an appropriate political entity that is prepared to assume the power to make these rules or to make these laws. I think what we have to wait and see from the first nations is whether they are prepared to say, "Look, here is a self-governing entity that should make that determination."

Mr J. Wilson: So for the record, from the first nations themselves, we have had no official request with respect to this particular legislation at this time that you know of through the native affairs secretariat?

Mr Krasnick: Other than the brief that was presented to your committee.

Mr J. Wilson: The one brief we received.

Mr Krasnick: But there is a consultation process in place that has a deadline of this week.

Mr Beer: In going forward with this legislation and how it would relate to the native people in the province, I wonder if we could just put on the record while you are here a way of describing the present situation, because I think sometimes it is very confusing to the layperson exactly how those relationships exist. The province over the last number of years has been moving both in terms of social services and in terms of health care into different arrangements that could best be described as a kind of local government relationship with a number of the bands.

I thought I would focus on the hospital in Moose Factory, which is run by the federal government. In terms of the discussions that are ongoing and in trying to place that in a

context of self-government, is it your thought that we could end up with a whole series of different relationships, where for example a hospital such as that might be run by the local native community, either on a contractual basis with the federal government and/or with the province for certain kinds of specialized services?

In terms of the actual administration of health care, the delivery of health care services, what is being discussed, or is it just that there are going to be perhaps a series of way stations along to something that might be a much more independent kind of operation?

Mr Krasnick: I think there are really a number of aspects to your question. First, there are clearly hospitals and facilities where, because of the need for upgrading the facility, the whole question of governance has come up. What has been talked about, although again it requires a consensus, as you know, of a large number of people and groups and governments, is some sort of joint management capacity. That is number one. Throughout northern Ontario, those are usually done by a series of aboriginal communities, if I can put it in those terms.

The Nishnawbe-Aski Nation, which represents 46 northern communities, has put before the native affairs secretariat and the Ministry of Health a proposal for self-government in health. They have just completed a community needs assessment on the social service aspects, if I can call it that—it is sort of broader, more health and social services—of their communities. They are putting together a proposal to us which will look at how that sector can be governed. That would be much closer to what we have been talking about as self-government, taking over all the reins of power. So that would be for the broad community of the 46 municipalities or the 46 first nations in that area.

The third aspect, which is quite new to the discussion, is the aspect not of the service delivery but the question of regulation, which is what we are talking about today. Within the continuum of what we have been dealing with, this is quite a new type of proposal, because it raises not a question of service delivery but a question of regulation. That is why we are not as sure in terms of what the consultations will bring.

1420

Mr Beer: May I pursue this? Using the example you mentioned, assuming that went forward and there was an agreeable solution, then health and social services, let's say, would then be run by the native people. Where would the province fit into that, both in terms of services and in terms of regulation? You have not finished the discussion, so it is hard to comment on that, but what would you envisage the province's relationship with the natives would be in that kind of scenario?

Mr Krasnick: Our hope at one end of the continuum, if we could reach it, would be a federal-provincial first nation agreement which would provide for a framework for the first nations to exercise powers over provision of the services plus a separate fiscal relationship type of agreement which would deal with the issue of how to fund these institutions as they occur. This area is particularly complicated because you have throughout the north, as you know,

federal nursing stations, and you have hospitals which are federal but which are very heavily funded by provinces, and vice versa. There is not a clean sort of jurisdictional capacity which anyone exercises. It has been melded together as people made agreements over the last decades.

Therefore, what we would like to see would be legislation passed by both the federal and provincial governments which would provide for legislative room to be exercised by the Nishnawbe-Aski, and a fiscal relationship arrangement which would give them some security as to their financing. That would be the optimal. From that, all sorts of practical problems will emerge and those are the things we think we will have to have more specific agreements on. I think that is where we would like to see it going down the road.

The Chair: Mr Jackson, question?

Mr Jackson: Are you expecting that I have just one?

The Chair: You had some questions this morning of Mr Schwartz that I assumed you would want to ask the secretariat.

Mr Jackson: We have several. I am not abundantly clear about the relationship between the federal and provincial governments. My limited understanding of the way federal legislation works with native Canadians is that where the legislation is specific, jurisdiction is clear, but where there is an absence of specific legislation, the provinces have a certain degree of primacy. Where health services are provided by the federal government in general terms, the matter of regulating health professions is very clearly a provincial responsibility.

Given those sets of understandings that I have, and we may share, I am trying to determine, other than native peoples who request it, who specifically says, "This is a jurisdictional matter for the provincial government; therefore you should be dealing with that matter as opposed to waiting to be asked for it." Do you understand the nature of my question? If we sit back and just wait for the native people to come forward, they may not be aware that we are proceeding with legislation dealing with regulations if the federal government has not told us, "Now that you are proceeding in this area, you better check with native people for its impact." Because federally, the government is saying the province is in charge, and the province is saying, "Health care generally is federal; regulation is not, but we do not have to trigger it."

I established this morning that Mr Schwartz was not asked to look at it from that perspective. If that is the case, I am trying to determine if this is a case where we just did not feel it was appropriate or both jurisdictions were waiting for the other to suggest we should be.

Mr Krasnick: Let me answer from two perspectives. One is the self-government perspective. The self-government perspective with respect to the Nishnawbe-Aski, which covers the majority of communities in the north where they have put the question of self-government and health on the agenda, allows them to ask for self-governing legislation or agreements in areas such as this. Therefore, if that was the case, the legislation would be passed by both the federal and provincial governments; and if that was the case,

that would have the possibility of, as you say, being specific legislation which would push out provincial authority.

They know in a sense that this issue is one of the issues that they have to consider as they are preparing their proposal on health. They have not submitted it to us, as far as I can recall. Therefore, in that instance, the question of federal and provincial responsibility is clear. It is a provincial responsibility, but they do have the capacity to ask the federal government to legislate and in that way take the province out of the legislative jurisdiction.

As I understand it, the first nations are now apprised of the initiative and are working towards providing us with their views at this point. I am not as clear on whether or not the question of provision of services on reserve under federal auspices is as straightforward as that. You may be right, but my own sense has been that there have been instances where federal doctors do not have to be regulated in Ontario to be able to practise in Ontario. So there are those types of questions as well.

Mr Jackson: Part of the basis for my question is for off-reserve treatment and services, because it is much clearer when dealing with status natives on reserve. That is a lot easier to deal with. But there are a large number of off-reserve and some non-status first nations people who still should have the right in this province, one would suspect, to have the choices for treatment according to traditional patterns, and presumably our health system, with its regulatory framework, should accommodate off-reserve concerns, because an incredibly large number of medical treatments occur off reserve in this province.

We seem to have crossed over a line as it deals with midwifery. It is to its credit that we are developing a model which will accommodate native interest within the regulatory framework for midwifery, but we are not seeing it anywhere else. I am confused because we have some initiatives created, which we now understand were done through the midwifery movement, but we are not seeing it in the other areas. Yet we can see it in terms of naturopathy and we can see it in terms of any of the psychological-based support services, especially in the north. The part that concerns me is that we are not dealing with that group who are not necessarily on reserve.

Mr Krasnick: I think it is an appropriate concern. When I started, I was talking about the corporate policy which talks about ensuring that the provision of services meets the needs of native people and supports the protection of their cultures and that the service is culturally appropriate. I think that is exactly the type of thing the process has to provide for. Those are going to be things which will have to be addressed.

It is also true that the consultation taking place through the friendship centres and through the Union of Ontario Indians and through the native women's association is the type of consultation which includes both on- and off-reserve people. In that sense they should all be covered by it.

1430

Mr Jackson: Not to stay on this point too long, let me give you an example to demonstrate the concern. Another committee that met dealt with the issues with native children

in regard to solvent abuse, which is a very serious problem in parts of this province. The incidence rates are incredibly high.

The native leadership will tell you that they are not dealing with certified professions, because they really cannot say they are providing a native program in the true sense of the word unless they have people familiar with traditional native methodologies. But it would be fair to say that there are some programs that would be operating outside of this legislation because the personnel providing them were not certified in accordance with the regulation, and yet traditional native methods would be recognized and would be followed.

Do you see the nature of my concern? These are all provincial matters, the delivery arm in some cases social services but invariably through a school system which also has some provincial jurisdiction as well. That is the area of concern I have. The one substantive native presentation we received brought this point to our attention: "Are we operating illegally or legally?" To what extent can other professionals who are not members of the native community come in and say, "Look, you can't be operating this program unless we're providing it for you"? Now we are into a jurisdictional dispute, and clearly the legislation, by its silence on these matters, does not offer the protection for native leaders who are attempting to provide the programs.

That was the nature of my concern. I think all of us are unresolved as to how we are going to overcome this in the absence of extensive consultation with native leaders on this point.

Mr Martin: I have a question somewhat along the same lines. In light of the fact that discussions are ongoing and will evolve, and the jurisdictional haziness that is out there around a lot of these questions, are we in fact on the right track re the native community, in principle anyway, attempting to advance and protect public interest, protection from unqualified providers, provision of high-quality care and then a scope for the evolution of the delivery of health services?

Having said that, how does that fall into what I consider—because I have interacted quite a bit with the native community in the north, coming from there—the native community's propensity to take care of its own and to come up with communal answers to individual problems that sometimes are not in need of the professional intervention that we often get into the communities that we live in? Are we in fact on the right track?

Mr Krasnick: My sense is that the legislation is on the right track because there is also the capability, as I tried to point out in my discussion of negotiating self-government, to look at self-governing arrangements which include not just on-reserve communities but also include a discussion with what we call urban centres. I think there are ways in which we can look at other culturally appropriate mechanisms or organizations or, if necessary, even amendments to legislation as we get the results of the consultation and the results of the self-government proposals that we are just starting to get in.

My sense is that what this legislation has done is started to begin a thinking in the aboriginal communities

about the best way for them to proceed and to raise all these types of questions. They will over the next number of years, I think, start coming in with proposals which will come to grips with the relationship between their traditional forms of healing and the regulatory system we are putting in place.

Mr Martin: Just to follow up on that, this morning there was a fair amount of discussion around the issue of a harm clause, which has been dropped at this point, but we were encouraged this morning to bring it back in. The question is, would that impede the ability of some of the traditional healers or types of healing to happen in your communities if we were to implement that? Then, going along with that is the issue of diagnosis. My sense of the problem is that in diagnosis you want to get to the root cause of an illness. There is treatment and there is diagnosing it so that you do not have to do treatment any more.

In terms of the native population, do you have any comment on that and how we might move with that so that it might be more in line with how the native community sees illness and how they would like to treat it, how they would like to see it dealt with rather, without using those terms?

Mr Krasnick: At this point, I think what we are really coming up into is sort of a native health policy which I think will flow from some of the negotiations that are currently under way. I am not really sure on either count how that will interact with the legislation. I just do not know.

Mr Martin: Or if what you are doing now in some way is in sync with that, or would this put us out of sync?

Mr Krasnick: I am just not sure.

Mr J. Wilson: Mr Schwartz this morning indicated that this committee, notwithstanding the concerns of natives, should not hold up this legislation, and that this can be dealt with later. As a native secretariat, do you have any thoughts on what we should be doing with this legislation in particular? Clearly the natives who appeared before us would ultimately like a parallel governing structure. I would like to know where the government stands on that before we move forward with this legislation. I do not think we should leave natives out of it.

It is something that clearly was not within Mr Schwartz's review, but it has certainly come to the attention of politicians in this day and age, particularly with the government's signing of agreements with natives. This is one of the first major pieces of legislation, and I think it could do irreparable harm if we go ahead and do not at least try to work on some amendments.

I do not know whether the secretariat has any comments on exemptions from certain controlled acts. Mr Martin referred to the diagnostic act. They want a provision in the legislation for native regulation and governance particularly of aboriginal, traditional midwives. In reviewing the testimony before this committee, they certainly were looking for I think—and I stand to be corrected—a separate college of midwifery for natives, and raised some very legitimate concerns there.

Does anybody have any comments? I want to know where we are going with this legislation, and that is the purpose of this half-hour, I think. Maybe the parliamentary

assistant could fill us in on what the government's intentions are in this area.

Mr Wessinger: I understand there is a consultation process now going on with respect to this whole matter. Certainly it is my understanding that this legislation will be proceeded with, and when the consultation is completed with the native peoples, I think that is the appropriate time to look at whether there are amendments required or whether it is to be dealt with under regulations. Certainly with the whole question of midwifery, we have not even got to the stage of looking at the regulatory framework. I think certainly there is quite an opportunity for this matter of midwifery to be looked at at the time, time for consultation to occur and time for input with respect to that whole regulatory framework.

1440

Mr J. Wilson: But this issue is, I think, far too important once again to be left up to the advisory council. We are giving this advisory council just enormous responsibilities and tasks. Is the government contemplating bringing in legislation so that legislators will have an opportunity, or is this all going to be handled through the regulatory framework?

Mr Wessinger: No, I do not think we are saying this will be a matter for the advisory council to deal with. I think we are saying it is a matter for the government to deal with once the consultation process is complete.

Mrs McLeod: I am going to try to paraphrase what I thought I heard Mr Schwartz say at the committee this morning, which was that the question of special concerns of first nations had not been dealt with in the Health Professions Legislation Review, that it was his sense that as the discussions of self-determination proceeded on a step-by-step basis, if the first nations opted out of the regulatory system and opted for a different regulatory system, that was clearly possible. Then this legislation would essentially be less than relevant for them. If they opted in, or if there were differences between what some bands or nations chose versus others, there would be an opportunity to change this legislation fairly readily to adapt to concerns of those bands or nations that chose to be regulated under this act.

If I have paraphrased that correctly, it would suggest that we could move ahead with the legislation without an injustice to the self-determination and self-government discussions that are going on. I wonder if you could say whether or not that position would raise immediate concerns in terms of its impact on either the first nations or the discussions you are having right now.

Mr Krasnick: No, my sense would be that they would understand the context in which this legislation was being brought forward, that there was a capacity in the province to amend the legislation or enter into self-government agreements which would deal with services, or for the federal government for that matter, in implementing an area or a type of self-government agreement, to also legislate in that regard. So with respect to self-determination, I think they would feel they are still looking at their potential ways of doing it.

The other question then is that one of the things they are thinking about is where this would fit within their self-government priorities. I think their priorities to date have been more around the question of access to lands and resources, in terms of the provision of services per se, as opposed to the regulatory side. So I think they would understand the initiative.

Mr J. Wilson: Just to comment on that, I am the former assistant to the federal Minister of Health. We negotiated a number of agreements over time and the last agreements we could not get were with Yukon and native people and bands in British Columbia. Exactly their number one priority out there at that time seemed to be to get self-governance in health care. I cannot see that native people in Ontario would be any further behind in those. You are telling me that this has not been a big priority to date with them?

Mr Krasnick: On the regulatory side, no, the priority has been around—

Mr J. Wilson: Lands and land claims?

Mr Krasnick: And services. No disagreement that health is not a big priority, but it has really been around the provision of services of a standard that is equal to that provided to other residents of the province. That is where the priority has been, and I think that may reflect the interest to date in this legislation.

The Chair: I would like to just pose a question and ask if it has been considered, either for this legislation or for other pieces of legislation, as an interim method, and that would be the concept of the ability to contract out. I know there are some pieces of legislation where parties can agree to contract out of the legislation.

Mr Krasnick: There is in the Child and Family Services Act a provision which provides for the Lieutenant Governor in Council to make regulations which would change the operation of the child welfare provisions that deal with specific aboriginal institutions or regulations. So there is a parallel that one could look at which would possibly—

The Chair: If such an amendment were brought forward to permit that in the context of this legislation, do you believe it would facilitate the negotiation and the discussions that are going on, or do you think it would not have any effect or would hamper the discussions?

Mr Krasnick: I think it would clearly signal that the government was open to different regional regimes. In that sense, it is positive. I would say that what the Minister of Community and Social Services has found with that provision is that unless you are specific as to whom it is going to apply to, a number of groups define for themselves that they should be able to opt out of legislation. I think it would have to be crafted to learn from the experience that Comsoc has been through, to make sure that you know that it is appropriate to self-governing bodies or entities that could take advantage of this in consultation with the province.

The Chair: Have you been giving any advice on that kind of a proposal through the discussions of this legislation?

Mr Krasnick: It may be a lame excuse, but to date, we have put our faith in the consultation process. Because of the diversity between both urban and non-urban and

northern and southern, we just want to see what comes in first. At that point, we feel our role may be more appropriate to start providing that advice then.

The Chair: We appreciate your coming before the committee today. Thank you very much for your presentation and also for answering the questions that committee members have put to you.

ORGANIZATION

The Chair: For the information of committee members, we have a full day scheduled for tomorrow, although you do not have that on your agenda yet. Because of the previous agreement to adjourn tomorrow at 3 o'clock, the suggestion is that in order to have sufficient time for discussions with the ministry, we shorten the lunch break and reconvene at 1 o'clock. So we would adjourn from 12 until 1 and then continue our discussions until 3. That is one option. The other option is to continue right through with just a couple of 15-minute breaks and see if we can get some sandwiches or something so that we actually do not have a lunch break tomorrow.

We are scheduled to start tomorrow morning at 10 o'clock and the schedule is quite full. We have for the rest of the afternoon an opportunity to debate some of the issues, question ministry officials—the Ministry of Health is here—and I would seek advice from the committee as to how you would like to proceed, both for the rest of today and tomorrow.

Mr Jackson: Could you or the clerk briefly advise us of what ministries are coming and in what order. I do not want to know how much time is devoted to each—I am comfortable with your judgement in those matters—but just who is coming and whether all invited ministries were able to attend. That is all.

Clerk of the Committee: Linda, you have a couple of outstanding matters, I understand.

Ms Bohnen: Yes. First, I can tell you who is coming tomorrow and at what time. At 10 o'clock is the Ministry of Community and Social Services; at 10:30, the Workers' Compensation Board; at 11, the Ministry of Education. The others which were requested, further to your request, were ONAS, which we have just heard from of course, and the Ministry of the Attorney General, which has declined the invitation. The clerk has their letter in response to the minister's letter, and perhaps it could be read into the record if you wish.

Clerk of the Committee: I have it in my office. I can read it into the record tomorrow morning or bring you a copy.

Ms Bohnen: The Ministry of Citizenship Office for Disability Issues has given no response as yet. I do not think we have a final response from the Ontario women's directorate either. We are a little uncertain whether they declined. Perhaps they have not confirmed that they have declined.

Mr Jackson: The language in these matters is most important, I appreciate.

Ms Bohnen: So what is scheduled is what I told you tomorrow.

Mr Jackson: What about seniors? They were the key ones I was interested in.

Ms Bohnen: I think seniors slipped through the cracks. We can get back to the Office for Seniors' Issues at the Ministry of Citizenship.

1450

Mr Jackson: I was just going to say, as you know, is not really a ministry. It is a secretariat with a couple of desks. Well, it is true. But we have not got a confirmation of Citizenship for disabled.

Ms Bohnen: My sense is that the issue for the disabled office within Citizenship was the attendant care issue. It is my understanding that because this issue had been dealt primarily with the Ministry of Community and Social Services, it was their view that the Ministry of Correctional Services presentation was most appropriate and that they had really nothing to add to that.

Mr Jackson: I have a concern with that, because we were trying to make the distinction between points raised and the position of the various ministries in these capacities. There is a world of difference between Comsoc as a ministry and the Office for Disability Issues, which has a partial advocacy component to it. In fact the advocate for the disabled, that whole committee of advocacy, is managed through that ministry. So our access to the advocacy group was through the ministry. Had we known that we were going to get this response, it would have been in the committee's best interests to call forward a representative of the advocacy group or the advisory council on seniors' issues or the advisory council for disability issues so that they could give us some form of a reaction to the legislation.

Mr J. Wilson: The Ministry of the Attorney General declined. Did they give us a reason for that?

The Chair: Yes, there is a letter that will be circulated tomorrow morning.

Mr J. Wilson: Does anybody know what the gist of the response was, just for the record?

The Chair: She is going to get the letter now.

Ms Haeck: Mr Hope was asking me why we were ending at 3 o'clock tomorrow and I have to admit the two of us are not sure, so could we get some clarification on that?

The Chair: It is out of respect for the beginning of the high holidays tomorrow evening, and in order to prepare to be in synagogue. Both myself and another person participating in these committee hearings have to leave by 3 o'clock.

Mr Jackson: We could not get along without either of you.

The Chair: On the other question that I asked regarding how we would like to proceed tomorrow, is there a consensus that we will adjourn for lunch from 12 until 1? Agreed. The hearings in the morning will be from 10 until 12 and then from 1 until 3.

Mr Burrows has some information for members of the committee.

Mr Burrows: The committee might appreciate what is kind of a status report on other questions. I would like to reiterate in relation to the last item that invitations were

extended to all of the ministries for which questions were raised and we were asked to arrange. Unfortunately, we cannot control the responses. As you know, there is no obligation for the ministries to appear. We still have not heard from one in particular at all, and another is unclear at this point. Hopefully, by tomorrow we will have definitive information from those two.

With respect to the other questions that were raised, we have a list. I would like to go through that list and give you a status report. It should not take more than a couple of minutes. Is that acceptable?

The Chair: With agreement? Yes, please continue.

Mr Burrows: These are under general headings and, Linda, please help me if I have forgotten a specific issue. There were a couple of items related to long-term care, dental hygiene and chiropody-podiatry. It is our understanding that the representative from the Ministry of Community and Social Services tomorrow will address those issues.

There were two items related to the provision of hearing aids. One was a request for information from the assistive devices program on access and monitoring, and in particular, more recent data with respect to access. There was also a question related to comparative costs for audiometric services. We will have for the committee tomorrow—I sincerely hope tomorrow—information of that nature. We have some of it. Unfortunately, some of the data, due to vacations and so forth, has been slow in coming forward. Also, it would appear that some kinds of data simply do not exist. However, we will certainly share with the committee what we have, and it is being put together as we speak. Hopefully, we will be ready for tomorrow morning.

There is information with respect to the provision of nursing. A question was asked related to standing orders: Does the ministry follow up on standing orders and retroactivity of standing orders? We have a package that we are tabling with the clerk this afternoon which covers, we believe, the answers to that question.

There was an additional written question related to comparison of licensing versus registration. Subsequent to the question being asked, it is our opinion that Linda responded. However, in questions and answers, if you would like us to elaborate upon that, we can.

There was a question related to the profession of chiropractic and the Workers' Compensation Board. In the written package that we are giving to the clerk this afternoon, there is factual information which we have put together with the assistance of the Workers' Compensation Board. Also, we expect that a representative from the Ministry of Labour will be here tomorrow to address any questions related to WCB policy.

There was a question related to the role of social workers under the Child and Family Services Act. We are responding to that in writing today. That is part of the package we are tabling this afternoon.

There was a request for consideration of the relationship of an exemption for acupuncture and concerns about the transmission of disease. I am going to report verbally on that right now. We have talked to the public health area of the Ministry of Health and we have been advised that in

their opinion no legislative change is required to public health legislation to enable them to enforce standards of aseptic technique or to prevent the transmission of disease. In fact they believe this can be accomplished under existing legislation. So I am reporting that back now.

There was also a request related to the experience of other provinces with respect to the self-regulation of nurses, and in particular, of practical nurses or registered nursing assistants. We are responding to that in writing. It is part of the package that we are tabling with the clerk this afternoon.

There was a question from the Ontario Pharmacists' Association related to the exemption for hospital pharmacists. I believe the committee's suggestion was that perhaps that question would be directed to Mr Schwartz. Unfortunately, I think we ran out of time this morning. I did not hear that question being asked.

Lastly on our list of questions to respond to there was a question about comparing or at least elaborating upon which other health legislation—and I believe it was Ms Haec who raised the question—that we have referred to so many times governs what health professionals may do in certain practice sites. That is being written. It is not part of the package we are tabling today. We hope it may be ready tomorrow. If it is not, we will certainly table it with the committee before clause-by-clause, no later than next week of course. We believe that list is exhaustive. Thank you.

The Chair: Comments or questions? Mr Wilson.

Mr J. Wilson: I do not have a comment specifically dealing with that list, other than to say I think it was exhaustive and comprehensive and well done. Would you entertain another question, though, that I have?

The Chair: Yes.

1500

Mr J. Wilson: I have a general question that came up in my riding the other day to deal with the controlled act of putting or probing below the dermis? What is the term? The legislative counsel knows.

Mr Jackson: Subcutaneous procedure.

Mr J. Wilson: Yes. I do not have the act with me. Sorry about that. The question came up that in a particular doctor's office, the receptionist was acting as a nurse and performing injections by needle and that there really was not any remedy under the current laws in Ontario to do anything about this. I understand how the proposed act we are dealing with deals with that as a controlled act, but what is the current status of that?

Mr Wessinger: I will ask ministry staff to reply to that.

Ms Bohnen: Under the Health Disciplines Act, medical acts can be delegated to non-medical people, including receptionists in physicians' offices, I suppose. You will see that one of the documents attached to the material given to you today is a publication from the College of Physicians and Surgeons of Ontario dealing with what they call sanctioned medical acts. Sorry, now they call them delegated medical acts.

That includes a comprehensive list of what may be delegated in institutional settings, but it also specifically addresses the skills or qualifications of persons performing

medical acts in the office setting. It does not list those, but it simply says that this idea of a physician in his office delegating to his or her whatever—receptionist, I guess—poses little difficulty, because the physician employs the person, knows his or her qualifications and there is an established working relationship. I think that the CPSO's view is that it was the responsibility of that physician who employed the receptionist to ensure that she was properly trained in the giving of the injections. So I do not believe, just from what you have told me, that it is unlawful.

Mr J. Wilson: Yes, that was my understanding upon investigation also, that there really was not anything to do about it. It really was not unlawful. Just in the context of our proposed legislation here, we are clearing that up, are we not? A controlled act will be—

Ms Bohnen: Under the Health Disciplines Act, in order for an act to be delegable, there is supposed to be a regulation under the Health Disciplines Act, and there is not. The legislation before you is clear that any controlled act, such as giving injections, may be delegated unless there is a regulation saying no, you cannot. So I think it is clear under the proposed legislation.

Mr J. Wilson: It is clear—

Ms Bohnen: Clearer. It will be clearer in the future that a controlled act may be delegated.

Mr J. Wilson: So if you wanted to prohibit those other than qualified nurses in a doctor's office, prohibit the receptionist from giving needles you would have to go to the advisory committee and ask for regulations?

Ms Bohnen: No. You would do two things. First, you would go to the College of Physicians and Surgeons and say to the council of that college, "We think you should make a regulation restricting or prohibiting this," or if you are a patient or whoever, I think you would make a complaint to the college about the physician who permitted this and, through the complaint and discipline process, induce the college to say that it is not in accordance with the proper standards of medical practice for a physician to permit his receptionist to do this. You would get an articulation of the standard, without of course judging—I am not in a position to say whether it is a good or bad thing to have people doing that.

Mr J. Wilson: It seems to be in the past few years that physicians are cutting down costs in their offices by not having to have as many nursing staff. I will say that for the public record. There seems to be a trend out there that I am clearly worried about, but thank you for your response.

Ms Bohnen: If I could just add—though remember, Mr Wilson, that you have also heard from people concerned about attendant care—that it is sometimes in the public interest to have non-professional people providing injections.

Mr J. Wilson: It is a very good point. Thank you.

The Chair: There is an opportunity now, and I will entertain the speakers' list if there are any issues that we would like to discuss now with ministry staff. Before we do that, we have just received a letter that was referred to from the Attorney General. Everyone is getting a copy of it, but for the record, I will read it into the record if you

wish. This is dated September 12, 1991 and addressed to the Minister of Health.

"Dear Ms Lankin:

"I am responding to your letter of September 10, 1991, extending an invitation to provide a representative of this ministry to the standing committee on social development on September 16 and 17.

"I am advised that law officers of the civil division of this ministry, seconded to the Ministry of Health, will be in attendance at the proceedings of the committee on those days. I have full confidence in their ability to address the relevant legal issues and answer any questions of the committee.

"I am pleased to be able to assist the committee in this fashion.

"Yours very truly,
Howard Hampton,
Attorney General."

Clear?

Mr J. Wilson: Clear.

The Chair: Ms Haeck is first on the list to raise issues for discussion. What I am going to do now, which is different from the process when we have had witnesses, is to entertain the speakers' list in order of who signifies they would like to speak. However, if one caucus tends to dominate, I will alternate through the caucuses to ensure that everyone has an opportunity.

Mr Hope: Just don't intimidate anybody from asking questions.

The Chair: I never. I always encourage people to ask questions, Mr Hope. After six weeks with us on this committee, you should be the first one to acknowledge that, I would think.

Mr J. Wilson: The fun has just begun.

The Chair: As long as you do not lose your sense of humour. Ms Haeck, please begin.

Ms Haeck: We have not lost it. In light of some of your earlier comments, it was most appreciated. Score 10. However, beyond that—

Mr J. Wilson: How has the score been run up?

Ms Haeck: They just do not know how well we have won on each other. Anyway, I would like to ask a question of legal counsel, through the parliamentary assistant. There is still some confusion, I think—"concern" is probably a better word—on the part of people presenting about the whole issue of the communication of the assessment diagnosis and there is this feeling of obstacles being put in the path of patients, having to run to various practitioners in order to get a full outline of what in fact may be the situation with their particular disease, disorder or dysfunction. I was wondering at this point in all of our discussions how to assure people that this is really not the intent.

Mr Wessenger: I will refer that to the ministry staff, but I think Mr Schwartz this morning certainly gave a clear indication of his position with respect to the legislation, being a lawyer and the creator of the legislation. I thought it was quite a satisfactory answer but I will refer it for more comments by ministry staff.

Ms Bohnen: I think one of Mr Schwartz's comments in particular that was useful was that, because of the nature of this beast, you cannot prove to people that their fears are not real fears. It is not like disproving a statement of scientific fact. It is not something really susceptible of proof or disproof except by experience. I think one of the things he said was that he did not think it would take very long, in actually living with this legislation once it is passed, for them to be much more comfortable with the fact that what successive governments and the ministry have been saying all along is, "You don't have anything to be concerned about." Other than that, they have not accepted what has been said so far, so maybe it just is that experience will have to be the teacher.

Ms Haeck: I appreciate that. We had further discussion of this at lunch and realized that it is still very much a concern uppermost in people's minds, to call on your X years of experience with this to reassure myself and the people who may be in the audience and other people who have presented to us that really that is not the intent and to clarify that any more if we possible can.

The Chair: Good idea. Could I suggest that ministry officials take these microphones at the other end of the table and that we could try turning on the air-conditioning and see if Hansard can pick everything up? It is very warm here. Can we try that out and see if it will work? Then you will have two microphones available.

Mr Wessenger: Then you will not have to put all the questions through me.

The Chair: The intention was to allow for questioning of the ministry staff. Any questions from any of the caucuses, any members of the committee?

Mr Cordiano: Just to say simply that staff has been pretty thorough in its analysis. I think we have covered just about all the concerns. Despite the fact that I was not here this morning, I understand it went very well. Most of our questions were deliberated on, any of the concerns that we had for Mr Schwartz were addressed, and I think the areas that you spoke about this afternoon where we had various concerns were touched on quite adequately. I believe we are ready for clause-by-clause, Madam Chair.

The Chair: We will have an opportunity tomorrow to have additional questions answered. Just for the information

of committee members, I would also point out that our researcher Alison has told us that she will have another interim report available for us as soon as possible. But there are still briefs coming in and, with the postal strike, the decision has been taken on your behalf to continue receiving those briefs, so we will not have the final report until we are about ready to start clause-by-clause. Alison, did you want to say anything on that?

Ms Drummond: No. I really do not have anything to add to that, but I hope to have the second interim summary of submissions ready tomorrow. I am hoping tomorrow, certainly the next day.

The Chair: The clerk has informed that, because of the postal strike, we extended the date for inclusion in the overall report until September 4. Anything received after September 4 up until this Friday will be circulated among all the members and will be kept as an exhibit that came in after the deadline and will of course be available. That is just for the information of all members of committee.

Mr Wessenger, you had a comment?

Mr Wessenger: I would like to compliment ministry staff. The fact that they are not be grilled with additional questions I think shows the amount of work and dedication they have put into this legislation and how competently they have advised committee during the hearings. I would just like to thank them for their assistance and, I am sure, their continued assistance in seeing this legislation through to finish. I would also like to thank, of course, all the committee members for their contribution and the Chairperson for all the assistance she has given me and I am sure will continue to give me.

The Chair: That being said, I would thank the parliamentary assistant personally as well as on behalf of all the members of the committee. I think we all found both the public hearings and the support from ministry officials to be very worth while in helping to have a much greater understanding of this legislation.

We will meet again tomorrow for the day to hear from other ministries, and I know that our Ministry of Health officials will be here at that time, in case anyone does think of anything over the course of tomorrow.

The committee adjourned at 1513.

CONTENTS

Monday 16 September 1991

Regulated Health Professions Act, 1991, and companion legislation / Loi de 1991 sur les professions de la santé réglementées	
et les projets de loi qui l'accompagnent	S-777
Alan Schwartz	S-777
Ontario native affairs secretariat	S-793
Organization	S-798

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

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Tuesday 17 September 1991

Standing committee on social development

Regulated Health
Professions Act, 1991
and companion legislation

Assemblée législative de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le mardi 17 septembre 1991

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent



Chair: Elinor Caplan
Clerk: Lynn Mellor

Présidente : Elinor Caplan
Greffière : Lynn Mellor

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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 17 September 1991

The committee met at 1004 in room 228.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

MINISTRY OF COMMUNITY AND SOCIAL SERVICES

The Chair: I would like to welcome everyone this morning, and I call first the Ministry of Community and Social Services. The committee asked you to appear, and certain questions were placed in Hansard and on the record. Can I assume you have a statement or a presentation to make before the committee and that this is how you would like to proceed?

Ms Freiler: We are flexible. If you would like us to make a statement, we could do that. Alternatively, we could just answer questions.

The Chair: I think it would be helpful to the committee if you made a statement first and then committee members can ask the questions they would like. Many members may have additional questions that would come from your statement, so that might be a helpful way to begin. Please introduce yourselves.

Ms Freiler: I am Christa Freiler, and I am Zanana Akande's policy assistant. I am here to talk about the social work act or to answer questions about regulation of social workers. This is Frank Wagner, who is the manager of the disabilities unit in the long-term care policy branch. He is here to talk about attendant care and any other questions of the committee.

Mr Wagner: I did review the Hansard questions. What I have attempted to do this morning is to synthesize those questions, basically as I understand them, to address the impact of the legislation on disabled persons, which was certainly a focus of the committee, particularly around the kinds of exemptions for self-directed and non-self-directed individuals, their desire for independence, the impact on the Ministry of Community and Social Services and how people access these services, particularly, again, in the context of the long-term care redirection. I have tried to synthesize my response in terms of those. I think that covers most of the questions around the attendant care issues.

Having attended some of the hearings, I realized there was some confusion as to where the attendant care programs

lie at the moment and what the legislative base is, so if I may start with that.

In fact, the redirection of long-term care has as its focus the consolidation of existing programs that provide services to the elderly and disabled persons. The consolidation at the moment involves the home care program, which was formerly a Ministry of Health program, the integrated homemaker program, the homemakers and nursing services program and the attendant care program. Again, I realize there was some confusion as to where these programs lay.

Of these four services, the attendant care program is the only one currently providing services defined as controlled acts in the proposed legislation through paid staff who are not usually members of the nursing profession. The other programs we have talked about are mainly related to and are mainly administered by professional health care workers.

Consequently, the impact of the introduction of the controlled acts on the attendant care programs and on disabled persons has been of concern to consumers, service providers and staff, both of the Ministry of Community and Social Services and the Ministry of Health. You certainly have heard presentations to that effect.

Since 1989—which is a direct answer to one of the questions—there have been discussions between the Ministry of Health professional relations branch and MCSS's community health and support services staff involved in policy development for physically disabled persons, the Office for Disability Issues, organizations and members of the disabled community and, most recently, quite a number of the people who did make presentations here as well.

Based on the questions as raised in Hansard, I think what will be most important at this point is to clarify the role of the attendants and those procedures defined as controlled acts and to discuss a type of exemption under the Regulated Health Professions Act.

The attendant care programs were originally funded by the Ministry of Community and Social Services and now lie in the community health and support services division, which is a joint division under the Ministry of Health and Ministry of Community and Social Services.

Attendant care programs, as you are aware, have been operating successfully for years. You heard considerable testimony of the fact that individuals like these programs and that they have enabled a considerable degree of independence that was not obtainable before, without these services. Services are provided by trained attendants in designated apartment settings termed "support service projects" or in the disabled person's own home through the attendant care outreach program.

Again addressing a specific question, until such time as legislation is introduced or consolidated, the authority for these programs remains in the Ministry of Community and Social Services Act. I was part of a session where I heard

that question raised: What is the authority for the attendant care programs? It is in the MCSS Act, which gives the minister very broad powers to develop programs in that area.

1010

The premier criteria for eligibility are that the applicant is 18 years old, the disability is permanent and there is a need for assistance with the activities of daily living. That is very important to stress, as we believe, as you have heard, again from disabled community groups and individuals, it is one of the key factors in looking at that.

We have defined activities of daily living as mobility, transferring, positioning, meal preparation, eating, cleaning up, dressing, undressing, going to bed, washing, grooming, shampooing and toileting, including bowel and bladder procedures—which are really possibly controlled acts, and that is where we want to focus our attention.

In addition, again related to one of the presentations, over the past two years there has been much pressure to admit persons with severe respiratory conditions, sometimes with a tracheostomy, usually requiring mechanical ventilation on a part-time basis. We are certainly aware of the presentation made by groups, such as the Committee for Independence in Living and Breathing, which were here before you.

Three or four ventilator users have already been admitted to support service projects and several more are served through the outreach program. Consequently, tracheostomy suctioning, which is interpreted as another controlled act for a health care professional, is being performed by non-health professionals and has been for a period of time.

It should be noted, and this is the key point I would like to make, that all of these procedures, including those defined as controlled acts, are essential routines for daily living for the persons requiring them. That is the fundamental issue, as we see it.

I would like to conclude by saying that what we are attempting to do in terms of the redirection of long-term care is look at the continued and expanded use of non-health professionals in the community settings. This is not to say, however, that these individuals would not be trained, and that is where we intend to put a lot of our focus.

In an effort to accomplish that, we are suggesting at this time, although it is still a suggestion, that we look at a continuation of the program we have developed which is training attendants in skill procedures, so they can meet the requirements defined as controlled acts under the new Regulated Health Professions Act.

Currently, attendants' training is provided by in-service instruction and practice by an agreement with the local community college or by purchase of service from a nurse who is registered with the College of Nurses of Ontario. We intend to continue that. It is our suggestion to continue that, to make it more rigorous and to develop both generic training programs and specialized training programs.

Included in some of the generic training programs for in-home workers will be certain procedures which are defined as controlled acts. This would cover those individuals, such as seniors or the head-injured, who may or may not be able to self-direct their own care as well, but should have the same opportunity as other individuals to access

services in their home and to access timely and, in most cases, non-health-professional services, which are much more readily available.

We are also talking about individualized training for those procedures that are considered more specialized, where individualized instruction and training are planned for these procedures. That would require professional instruction and, in some cases, a delegation of authority from a licensed health professional, who would basically ascertain that the training was of a sufficient standard and that the person was competent to deliver that service on a one-on-one basis.

Basically, if I may summarize, we are certainly interested in an amendment to the Regulated Health Professions Act, and there has been correspondence between the deputies of Health and MCSS to this effect. There has been correspondence by the previous minister responsible for disability issues to various advocacy groups and representative groups indicating that this is desirable, as well as the announcements by both the previous minister and the current minister when the legislation was tabled indicating that this was a desirable end.

By way of summary, what we are talking about is that persons or acts themselves should be exempted when the procedures defined are essential routine activities of daily living for the person requiring them, when the person performing these is a family member or when there is an agreement between that individual and the person providing the services; and in other cases, such as the case of children or those vulnerable individuals, where a regulated health professional has ensured that those services are of a certain calibre and standard and that person can perform those services.

Mr J. Wilson: In the area of title protection, with regard to the language in each of the bills that reads "titles are protected in the course of providing or offering to provide in Ontario health care to individuals," it has been suggested by a number of groups that perhaps that should be deleted. Because in the area, for example, of speech-language pathologists or audiologists, where they may do consulting in the education field or community and social services, the titles that are to be protected and some that may be introduced by amendment are only being protected in the health care field, and it would be better for consumers if they understood that a speech therapist was a speech therapist across the board, whether in a health care setting or at Comsoc or working for the government, as we have some on staff. Any comments from Comsoc on that? Did you look at that area?

Mr Wagner: Interestingly enough, it has not received the interest or the discussion that the area I just addressed did, the attendant care issue. Other than information provided as a courtesy, for instance, from the psychologists or the speech-language pathologists, etc, we have not been directly affected by that in terms of ministry policy work or lobbying activities. There has been very little in relation to that title protection area. It has not been a significant issue for us.

Mr J. Wilson: That is strange, because we have had about three or four major areas of concern from most

groups, and one of them has been title protection, trying to get a feel from the government whether other ministries have objections in this area. I was under the assumption that perhaps other ministries did have objections, Comsoc being one of them, because for some reason this language was put into the act.

Mr Martin: In presenting a package of regulations such as this that comes out of one ministry but has tentacles that move into the realm of other ministries as the whole notion of health care evolves, particularly in the area of mental health and community mental health and community mental health programs, I would like to hear you share with us some of the direction in which the ministry is planning to go re the whole community mental health field and scene, whether there are any ramifications of this legislation that might cause you some concern, particularly in the area of the ability to diagnose, and going back to some of the title protection concerns that were raised around the issue of, for example, psychologists not having sole possession of the terms "psychological" and "psychology" re what mental health workers do in communities.

Ms Freiler: I think we will have to get back to you. We came prepared to answer specific questions and we would have had to bring other people with us to answer that.

Community mental health right now is in the joint division between the Ministry of Health and the Ministry of Community and Social Services, and the only contact we have had on the issue that relates to what you are raising is with the group that had concerns about the independent therapists. I cannot remember; I think they made a presentation to this committee.

Their concern was that they were excluded from this. They were also excluded from regulation because they were not doctorate psychologists. They raised a number of questions that they presented to a number of ministries, and I think they made a presentation here. I understand this is being resolved, but we will have to talk to people in the community mental health branch and get back.

1020

The Chair: Could I suggest that it might be appropriate for you to respond in writing or have the individual respond in writing to Mr Martin. Then, if he wishes, he can share that information with the standing committee.

Mr Martin: Just so you know and actually do your research or talk to your folks about this, some serious questions have been raised from people who would fall under, I would think, the mandate of your ministry more than the mandate of the Health ministry around the issue of the harm clause and the diagnosis clause and their ability to do their work in the community.

Because, as I sense, the Ministry of Community and Social Services moved to have communities heal themselves and be creative in the way in which they might respond to mental health needs and how even education might get into the act in terms of delivery of service and all that, there are folks out there who are doing work now in the mental health field particularly who are concerned that this might put them in jeopardy as they continue to do that.

Yesterday, as I talked to Mr Schwartz, I shared with him an example—I was involved in a lot of community work over the years. It became common knowledge that people who took, for example, teams of young people on trips got into accidents, whether big or small, and were sued; some of them got into lawsuits that cost them their livelihood. They more and more backed off doing those things that we all took for granted as a good thing to do and good for community mental health and that kind of thing. I am afraid that with some of the legislation we are looking at bringing in here, we might have the same kind of impact, that people might back off and say, "I'm not going to be involved in that any more." I think you take away a valuable resource from a community as it tries to deal with some of the problems it confronts.

I will be interested in Comsoc's response to that on whether there will be an impact.

Mr Jackson: My area of concern has to do with how well this legislation anticipates some of the changing needs within the ministry as it relates to long-term care reform. In particular, I would like you to talk in more detail on the items you referenced earlier about the responsibilities of family members who are providing care of a routine nature versus providing care that in another setting clearly is regulated and requires the supervision of another professional.

I know I am asking you to look into the future, but there are sufficient pilot models for community-based health care now where this situation would emerge. I am anxious to determine if the ministry has analysed that and can guide this committee to ensure that the legislation before us is sensitive to that changing direction in which we are going to evolve in the coming decade.

Mr Wagner: It is a very difficult question to respond to, because of course things have changed so much in terms of the interface between health and social services. Things will continue to change, and the impact of the medical technology is of such significance in what we are talking about that it really does directly impact.

We do believe overall that the proposed legislation, as we understand it, will have a positive effect in the areas you are talking about, provided some exemptions are obtained, for instance, for family members and other non-health professionals, particularly in the areas you are talking about, which I was alluding to and also have some experience in, mainly those individuals with those kinds of conditions which were not even around 5 to 10 years ago. For instance, ventilator-dependent individuals were not around in a formal setting; they have been around for many years in terms of, for instance, polio survivors on respirators for many years in the community and there was no attention or no interest paid because they were coping as best they could with family members.

However, we are talking about new phenomena largely related to the impact of trauma units and the ability of health systems to save individual lives with the possibility of very sophisticated mechanical and other supports. I really think that is the area; also, chronic care situations that require immense amounts of support and help.

At this time, we do not know the extent to which we can respond. We are certainly trying. There are pilots, as you suggested, relating to the care of individuals both by family members and supported through health professionals and non-health professionals. What our experience has been, and I think you have heard this from the presentations so far, is that most parents and most individuals can do the sophisticated procedures provided they are trained.

Mr Jackson: Let me lay out for you the specific concern I have. In this world of eternal optimism one would hope that all experiences for a patient in a home setting are wonderful, are supportive and done to a professional level. However, if one were to cite the cases of elder abuse, of certain forms of family abuse which the system does not necessarily check, it puts a great onus on this committee and the work before it in areas where we are taking someone out of a hospital setting, where this legislation clearly defines the professional conduct, and putting them into a home setting.

I am not going to disagree with you that our capacity to move to a home setting is enhanced greatly. However, if a senior citizen in my riding is in a hospital for dialysis, he will have the direct supervision of a doctor, and a nurse with urology experience will be doing the hookup and the disconnect and will be doing some monitoring. When we move that to a home setting, we now have a very confused set of liabilities that flow between the family and the nurse because some of the training is done by the nurse to the family member. We drop, in a sense, the legalities and the supervision of the physician in the urology department.

That is of concern to me and to seniors in this province, and I am trying to determine the extent in which ministry thinking, legal or otherwise, has evolved to look at that issue. Certainly that situation is occurring now, and the legislation we are about to implement will impact on that environment.

I am looking at the downside, which unfortunately, statistically, we are finding out is much higher than we had anticipated in this province. Can you address that: As opposed to knowing that we are going to do it because we are able to do it, that we are going to do it because we have to?

Mr Wagner: At this time our analysis, including a recent study we have done on high-care needs of individuals, has not shown that. Neither has some of the material we have from other jurisdictions. What it has shown, in fact, is that with care in the home, the number of hours and the kind of care and the risk of infection, by and large, are less than in the hospital setting. So our community data do not support that necessarily. The issue you raise is certainly well founded: the issue of liability and that delegate—

Mr Jackson: Supervision of professional medical services, which is what we are here to deal with in this legislation.

Mr Wagner: And also, on the upside of that, the notion of having professional standards, having standards that are applicable to the home community, which we support. We are saying there have to be standards. There should be, besides this legislation, different ways of enforcing those standards, rather than relying on this legislation to do that.

This would allow us the flexibility to use non-health professionals in this kind of setting.

Mr Jackson: Madam Chair, if I could simply ask a one-line question, because I sense I am not getting far with this question—

The Chair: You are just not agreeing with the hypothesis, Mr Jackson.

Mr Jackson: I was not laying out a hypothesis. I was simply asking if the ministry has examined the issues as they relate to home-based home care, where family members are now involved in not necessarily simple, routine procedures but complex medical procedures, and who is responsible for supervision. I simply ask the question this way: Does this legislation, in your opinion, deal at all with home care programs in this province that are run through your ministry? If so, how does this legislation impact that directly?

Mr Wagner: It impacts it both directly and indirectly. I refer you again to a study we have just completed, The High Care Needs of Individuals, which is certainly available through our office and which I think will answer some of those detailed questions in terms of what data we have. In terms of home care programs and those other programs I mentioned, that package of programs which we are trying to rationalize, it will provide standards for health professionals and non-health professionals. That is the intention. Hopefully, in those areas you are speaking about, in those areas where there is some question and some risk, significant risk, there will be a mechanism worked out through the colleges that will permit transfer of responsibility without necessarily relinquishing authority, which is what I think you are getting at.

1030

Mr Jackson: So the legislation is silent on it at this moment, but you are doing work on it.

Mr Wagner: We are anticipating further discussions. Depending on the nature of the exemptions, we are anticipating discussions with the colleges and we are working with them.

Mr Jackson: With the individual colleges?

Mr Wagner: That is right.

Mr Jackson: The ministry has given you a mechanism and a plan for discussions for that, and you are actively reviewing this legislation with a view to looking at community-based and home care types of programs on the critical issues of professional, medical, support services and the supervision thereof?

Mr Wagner: We have been doing that since we were made aware of the potential impact of the legislation when it was tabled.

Mr Jackson: That was some years ago, yet you have not provided any concrete proposals, or you are not impacting this legislation.

Mr Wagner: Partially, that is because we are also talking about the reorientation of long-term care, which is still in its infancy.

Mr Jackson: Okay, I think we have enough.

Mr Solá: I have subbed on to this committee several times. A social worker made a statement I found disturbing, that 80% of the mental health cases that came before him were misdiagnosed. The question period was a little short, but I got the impression that it was not a slur on the capability of the medical personnel who had diagnosed these people. It was just, I think, a question of how comfortable the clientele felt in a medical environment; they maybe let their hair down more when they were being interviewed by a social worker. I am wondering whether you find this 80% misdiagnosis to be province-wide or whether this was a particular case for the Sault area. Could you comment on that, please?

Ms Freiler: Neither of us have ever heard that statistic. I would like some clarification. Is this misdiagnosis by a social worker?

Mr Solá: No, the social worker claimed that mental health patients referred to him had been misdiagnosed by the medical people who had done the diagnosis. I was disturbed by this, but I do not think this was a slur on the capability of the psychiatrists or psychologists who interviewed the person, but just that, I guess, they were looking for something other than what a social worker looks for. Also, I think the clientele felt more comfortable talking to a social worker than to a psychologist or a psychiatrist. I am wondering whether this is a province-wide phenomenon or just maybe the case in the Sault area.

Ms Freiler: I think you are asking a question that is too important for us to try to wing it. Neither of us knows, but we will certainly find out in the next couple of days and get back to you in writing by the end of the week.

Mr Hope: I was listening to what you were saying. I listened to Alan Schwartz yesterday talking about how the system would have to be flexible. Listening to your answer to Mr Jackson's questions, are you saying that because we identify certain needs as the system goes on, as we start talking about care provided in the home instead of institutional settings we are going have to be flexible in order to accommodate, making sure that high quality is there? I have to ask you that. Along with that, do you see an ongoing rapport with the health professions working with the college—you made reference to head injuries—as we start the dialogue around the criteria? As you talked about criteria for special people, I just wonder about your comments on that.

Mr Wagner: I think we must show flexibility, because we are faced with areas where we had no sense, as I said, 5 to 10 years ago that people would even be surviving certain kinds of traumas or chronic conditions. I am sure the committee members are familiar with the kinds of conditions; I am sure you have had presentations on these. What we have to do, and I think what you are alluding to, is that we must maintain the flexibility so that people have the dignity of risk. They have already demonstrated they can survive the trauma or the disabling condition. We have to, to the extent we can, enable them to go about their lives in the community. We cannot restrict them to a medical model that would in fact force them to remain in a hospital setting. Again, I know you have had a presentation to this effect.

The way we do that is most difficult, I agree. I think it was what Mr Jackson was referring to. I think we have to use non-health professionals. They are available. We can do more with the number of people. In fact, they provide the flexibility we cannot find, because we cannot even access those numbers of health professionals even if we wanted to.

On the flip side of that, your reference to the head injury is a good example. In that area, there are very few standards or criteria right now in Ontario; there are very few anywhere, for that matter. I think we are looking to this type of regulation and this type of the development standards to help regulate that area.

Looking south of the border, we have seen extensive development of services, in some cases by questionable individuals, because of the lack of standards. We are suggesting that something like the legislation proposed could assist in establishing those standards—in effect, the issue of credibility and credentials—and then allow us to have the flexibility with the colleges to say: "Fine, we understand that. We can meet those standards, but will you permit us to go further and allow those individuals who want to go back into the community the risk, the opportunity to try to live, knowing that mistakes will be made?" Certainly the liability issues are real. They are real right now. If an individual performs a procedure, he may be liable for it now, just as he would be liable later when it is a question of competency.

Mr Hope: The second question goes to a slightly different focus, dealing with the proposal that was made to us with new language that was developed. I know you have been out of the office for a bit. Have you had an opportunity to sit around and discuss the language that has been proposed to this committee? If so, is it workable for the health professions regulations?

Mr Wagner: As I understand the last proposal, which came while I was on holiday, I think it does meet the needs of our ministry as well. Whether it be by amendment or regulation, it does provide a framework for activities of daily living to be exempt. That gives us the flexibility. For those kinds of individuals we were talking about who are in very risky situations, who are willing to take that risk, then I think we are talking about that model where there could be some regulation applied saying there must be delegation or supervision by health professionals.

The Chair: With the permission of the committee, I would like to ask questions along these lines as well. Any objection?

Mr Jackson: Who gets to cut you off?

The Chair: Not you.

Mr Jackson: I was looking for the job.

The Chair: I will not be too lengthy. I will try to keep it within the same time line as others.

We have discussed this issue before. The opportunity for individuals who are now able to live independently in the community and to make their own decisions around risk is seen as a quality-of-life issue. The dignity of risk is one which has been made very dramatically before this committee. We have all been looking for ways not only to

encourage and support that independence but also to respond to the desire of those individuals for what they were very clear and very articulate about, which was control over their own lives, making informed decisions. I do not think there is a group of individuals that has the opportunity to make more informed choices than in fact those people who are dependent on the kind of support and care which is now available because of new technologies.

1040

With that as an introduction, a thought occurred to me. I wonder if it has been considered. If it has, that is fine. If it has not, I would like to ask that it be considered as part of the policy development process as well as the amendment that has been placed, which everyone seems to feel will accommodate the desire for now, under the rubric of flexibility you referred to and the need to respond to both standards as well as the issues of liability and ensuring proper informed consent.

Your ministry has had some experience with the concept of contracting out of legislation. We discussed that yesterday with the folks from the native affairs secretariat around the Child and Family Services Act, where contracts are actually able to be developed between highly informed organizations or individuals. It seems to me that concept may have some real opportunity for this legislation, not only for the native communities but for disabled persons who, when properly informed, could establish the kind of contract upon leaving hospital that would give them complete control over their own lives and allow them to see that the individuals providing service were properly trained to a certain standard. Have you considered the concept of contracting out for disabled persons in the context of this legislation?

Mr Wagner: In the context of the legislation?

The Chair: In other words, an amendment that would permit disabled persons to enter into a contract with a provider that would save harmless the individual from liability under the legislation, give the disabled person complete control over the hiring, education and so forth and take the provider out of the influence, if you will, of anyone other than the disabled person with whom he has entered into employment. It is an idea. I am wondering whether it has been considered, and if it has not, whether you are willing to consider it.

Mr Wagner: I think we have attempted to practise it, in part, through our transfer payment programs to agencies, in fact to volunteer agencies which provide attendant care.

The Chair: At the present time, though, there is nothing in this legislation that would allow anyone to contract out of it.

Mr Wagner: I see what you are saying. In the actual context of the legislation, we have not discussed it in great detail except for the concept of delegation of authority to non-health professionals, which presumably could be contracting it. We have talked about pilot initiatives in terms of direct funding. We have talked about agencies continuing to provide the service to the individual and the individual making contractual arrangements with that agency for individualized service, which is the beginning of the model.

Where we are experiencing difficulty, as I alluded to and as the questioning did, is around those high-risk individuals and ensuring we have access to health professionals. Ventilator-dependent individuals and advanced muscular dystrophy patients are examples where the continuum is so blurred that we must have access. For that individual to continue to live in the community, he or she must have access to health professionals to establish that continuum.

The Chair: It was just an idea that occurred to me when we were hearing from some of the groups and organizations. I realize an accommodation has come forward with the proposed amendment to the statute, but I wanted to raise the question and ask that you consider that in terms of the policy developments that are ongoing. That was the context of my question.

Mr Jackson: Madam Chair, to the excellent point you have raised, just for the interest of the committee, the Ministry of Community and Social Services conducted a workshop all day Saturday with health care professionals and community agencies to deal with the issue you just raised. I sense that because of the deputant's comments that long-term reform is in its infancy and because this legislation is clearly before us, that means we are unable to merge the two, but it does not imply that the government is not undertaking discussions on this subject at this time. I have been briefed on a meeting that occurred as recently as last Saturday that dealt with this specific issue in part.

Ms Freiler: I believe that was not our workshop.

Mr Jackson: It might have been the Ministry of Health, but it was around long-term care. They were facing the various professional groups that were in the non-profit and the for-profit sectors, and this delegation of authority was clearly discussed, from what I was told.

The Acting Chair (Mr Cleary): I thank you for your presentation. It was very informative.

WORKERS' COMPENSATION BOARD

The Acting Chair: Next we have the Workers' Compensation Board, Tinie Van Schoor. Do you have some opening remarks you would like to make?

Dr Van Schoor: I have a few remarks I could make in terms of the impact on the Workers' Compensation Board and the legislation as it affects the chiropractic profession. Our concerns centre around a few points, and I would be happy to respond to some questions.

In the first instance, our legislation is clear that the injured worker is to make the initial choice of doctor or other qualified practitioner for the purposes of the Workers' Compensation Act. In that regard, we have traditionally recognized both medical doctors and chiropractic practitioners as being entitled to provide primary care under the legislation. We would be concerned if anything changed in terms of the status of the scope in which chiropractics were able to provide primary care.

This perhaps centres on some of the language distinguishing between diagnosis and assessment for spinal versus other joint conditions. I had some discussion earlier this morning and it would seem as though that distinction is not going to be critical in terms of allowing the chiropractic to

treat these conditions. The bulk of the conditions affecting injured workers treated by chiropractics is related to the spine, although we have clearly 5% of cases that involve joints of the extremities. We have some difficulty with our classification system, and we have another 23% of cases where it is not clear whether it is a combination of spine and extremity injuries. I just cannot pull that out of our data. So that is one issue.

The other side of it is that when we are adjudicating entitlement to benefits under the Workers' Compensation Act, we try to relate the diagnosis of the injured worker's condition, whether it be an injury or a disease, to the work circumstances. We have traditionally asked chiropractors to provide us with a diagnosis in order that our adjudicators can compare the diagnosis with the work circumstances and make a determination of work relatedness. Again, if there is a removal of the ability of the chiropractor to make a diagnosis, this could to some extent encumber the situation, although I would say a lot of it focuses around the definition of "assessment" versus "diagnosis."

Those are the issues that seem to be of concern to the compensation board. I would be happy to answer any questions.

Mr J. Wilson: Just to be clear on that, the current practice is that the Workers' Compensation Board does rely upon chiropractors to make diagnoses of the extremities?

Dr Van Schoor: Yes.

Mr J. Wilson: It is your view that this legislation may inhibit that practice by chiropractors?

Dr Van Schoor: Yes, depending on the definition of "assessment" versus "treatment." My understanding is that this would not exclude injured workers from going to a chiropractor, being assessed and treated, in that there is not a prescription needed at the front end before allowing them the choice of chiropractor. I would like to hear whether that is correct.

1050

Mr J. Wilson: In the Workers' Compensation Board use of the term "diagnosis," are you using the term in the same context that the College of Physicians and Surgeons of Ontario would use it, and certainly the context in which we have been asked to consider it? That is, you are asking chiropractors to explain the root cause of an ailment. Is that your understanding of the term?

Dr Van Schoor: Yes, especially for the purpose of establishing work relatedness. We require that kind of definition because the cause needs to be determined as to whether or not it is work-related. If you do not have the cause, obviously that task becomes difficult.

Mr Martin: In the light of some of the overlying principles of this legislation, one of them being that the public should be provided with a variety of choice in terms of how they want to be looked after when they have been hurt or when they are sick, do you see this legislation, in terms of your service, actually doing that? We have had folks come forward excited about the possibility of getting some further recognition of what they do and some legitimacy given to their method of health service. Will this enhance

and provide those people out there in our communities the opportunity to take advantage of health care that they see as the most appropriate for them?

Dr Van Schoor: My understanding is that this is the intent of the legislation. Of course, as with all these things, we are concerned with both flexibility and access as well as high quality of care. In that regard, we follow very much other existing pieces of legislation. I do not think the Workers' Compensation Board in and of itself really has or should have a role in determining which practitioners can practise what type of health care. We are inclined to follow on the definitions flowing from the Health Disciplines Act, from what the Ministry of Health determines, etc. We hope and trust that whatever is built in there addresses accessibility, cost-effectiveness and quality.

We have a separate responsibility to monitor the health care that injured workers receive and ensure that this is of the highest quality. Where there are unique services required by injured workers that might not be required to the same extent by the general population, we look at trying to facilitate and encourage the development of such additional services.

So I think we have a concern in terms of access and quality, but at the same time we see ourselves in a secondary role to the major agencies that regulate the health care professions. We sort of follow on from them. Our legislation defines health care in terms of medical, surgical, optometrical and dental, and then the whole group of drugless practitioners. My understanding is that this will widen the choice for an injured worker among the group of drugless practitioners, who can then provide primary care without having to first go through a medical person.

Mr Martin: I guess what I wanted to hear clearly from you—because you do pay the bills, and the person who pays the bills in this society usually calls the shots—is who you will recognize as a bona fide, legitimate health service deliverer. And, in light of the intent of this bill, which is to provide a range of choice to the consumer, will this legislation do that? I need to know that as I give my assent through this process, because we have had some letters presented to this group that have shown that the compensation board does in fact decide who can and cannot deliver service to the people it serves.

Dr Van Schoor: Certainly on an individual case we will evaluate the treatment a specific injured worker is receiving and see whether that particular treatment is appropriate at this time, relative to a type of injury. But in the broader context, as I said, we do not see ourselves being in the role of determining who can practise what type of health care, and we rely on other pieces of legislation to guide us. So in general terms, we follow the legislation that is out there, and if that changes, our practices will change.

On the individual case, each case is examined on its own merits. We have to deal with whether this particular practitioner is providing appropriate care to this particular worker. That is where there would be a specific power exerted by the board in terms of payment or non-payment for a treatment. But in the broad context as to who the injured worker has access to, we rely on other legislation.

We have in the past followed it, and we would hope to continue doing so, unless there were some extreme reason for us to deviate from that. As I said, we are not in the primary business of regulating health care professionals in the province. We need to rely on other bodies to do that.

Mr Martin: For many of us who serve in our constituencies, workers' compensation has to be the most frustrating, difficult thing we deal with in our day-to-day efforts to be of service to our communities. A lot of times it is because there are not clear definitions about what you can and cannot do and who gets what.

I was hoping that any legislation we would pass in our mandate would in some way assist folks out there to access services in a more direct and clear fashion. Maybe you are not able to tell me that, but will this legislation take away any of the grey area and lay out clearly what it is people can access and what they cannot?

Dr Van Schoor: As I said, in general terms, yes. In specific instances, I think this is where you meet some of your frustration. It is often not even so much whether the individual has access; we simply do not have the authority to pay the bill if a decision has not been made that the individual has access to benefits under the act. This is often the area of frustration: that the treatment might be appropriate, the patient has access, but the decision has not yet been clearly made as to whether the responsibility for payment lies with the Workers' Compensation Board or with the individual or with the health insurance plan. I think this is where most of the frustration comes. Sometimes these entitlement decisions are time-consuming and complex. That part of the frustration obviously would not be affected by this legislation. But in terms of general access for injured workers to a broader choice of health care providers, yes, it will do that.

Ms Haeck: I would like to follow up on some questions that Mr Wilson started to pose, and Mr Martin as well. The issue of diagnosis and assessment—disease, disorder, dysfunction—is one that obviously has been very much integral to this whole set of hearings. In the process of examining the diagnosis or assessment a chiropractor may make, what would be part of the documentation to review as to where a particular claim stands? I am looking at what kind of diagnostic tools or whatever you would expect a chiropractor to deliver to WCB in order to make a decision about a claim. What is the decision-making process?

Dr Van Schoor: In terms of the entitlement, what we are looking for is identifying the cause of a disabling condition.

Ms Haeck: Would that mean you would expect a series of X-rays to be included with this, or what else may or may not be involved?

Dr Van Schoor: It would depend on the individual case, but a range of things would be required, from your history, your physical examination, special investigation such as X-rays, all the way through the range to invasive tests. In the case of the knee, an arthroscopy might be required, access to CAT scans, magnetic resonance imager scans, blood tests, etc; all may be necessary depending on the individual case.

Ms Haeck: In that example, there is a limitation as to what a chiropractor is allowed to use as a diagnostic tool, so a chiropractor may not in fact have access to prescribing an MRI scan. That is my understanding. Is that yours as well?

1100

Dr Van Schoor: Yes.

Ms Haeck: You made the comment about an invasive procedure. It is also my understanding that they are not really involved in an invasive procedure. That is much more an external examination.

Dr Van Schoor: The only thing is that these investigations obviously are not necessary in all instances. I have some difficulty in understanding the distinction between the spine and the extremities. The current practice is that if the chiropractor suspects something which requires more investigative procedures than he has access to, he then refers to a medical doctor and the process flows from there.

I find it, from a medical point of view, difficult to understand the distinction, because in many instances the diagnosis of joint disorders of the extremities is a little easier and more readily done than in the spine. That seemed a little curious to us: Why make the distinction between spinal and other joints? But in practice, the process seems to work well except for the exceptional cases. Chiropractic professionals generally identify problems that they can deal with. They deal with them appropriately, and if they feel it is something outside their field that requires additional investigation, they very appropriately refer it to the medical profession. That has not been a problem for us from the workers' compensation point of view.

Ms Haeck: Definitely. We understand that professional arrangement is working well; I am not here to debate whether they have been doing that or not. But it has been a concern throughout these hearings about trying to determine what is a diagnosis and what is an assessment. The semantics of it has been a major issue for virtually every group that has come before us.

Dr Van Schoor: Even with the medical profession, when we feel there is insufficient data for us to make a work-relatedness decision, we will then ask for that physician or a consultant to become involved. We will often request that specific tests be done to assist us in establishing the causation issue in the case. Asthma is an example where, in the general management of an asthma case, the physician very often does not do the extensive tests that are required by the compensation board in order to make a work-relatedness decision, because the physician is basically interested in treating the condition, and whether it is due to pollen at home or some dust at work is not of major consequence to that physician. Of course it is to the board, and we will then request these special tests to be done to assist us in performing that function. That would continue unchanged. We would judge when we feel we require additional testing for decision-making purposes.

Mr Jackson: I would like to thank you, Dr Van Schoor, for your very clear and unequivocal presentation on the issue which this committee has been struggling with. Most of the questions I had have been asked. However, Mr Martin did say you pay the bills and therefore you should

call the shots; I always thought WCB was built on employer contributions in large measure, but that you still have the right to call all the shots. I just thought I would correct that little piece for the record.

Mr Hope: They are the gatekeeper.

Mr Jackson: That is true. They are the gatekeeper, and perhaps when we are \$6 billion in deficit position, or whatever they are at the WCB these days—I do not indict Dr Van Schoor with that, of course. He is providing a very valuable service.

However, I am interested in the specific requirements of WCB in terms of getting the various checks and subsequent rechecks by physicians and/or chiropractors. Am I to understand that under certain circumstances you are more than satisfied if there has only been a diagnosis done by a chiropractor and there seems to be remediation and rehabilitation occurring? Does that seem to satisfy WCB? Or do you still require an external doctor's diagnosis before you will process the claim in a certain fashion?

Dr Van Schoor: I would say in the vast majority of cases where the injured worker selects the chiropractor to provide the treatment, the information provided by that chiropractor is sufficient for our purposes of adjudicating the claim. It is the exception where additional information or additional assessment by physicians is requested.

Mr Jackson: My second question would have to do with your perception. Could you share with the committee whether, in your opinion, the change which inhibits the diagnosis of the outer extremities may cause an increased cost to the system, whether it be OHIP or WCB, by in some cases requiring additional diagnosis that may or may not have been necessary?

Dr Van Schoor: I think that would depend very much on the definition of "assessment" versus "diagnosis." On the report forms which we request the chiropractors to complete and send to us, we ask for a diagnosis. If the legislation goes through as it stands now, we may well have to develop an additional form to deal with assessment rather than diagnosis for the extremities. Whether that will then lead to the need for additional medical diagnoses to satisfy our needs, I am not sure. In practice, I think probably not, but in terms of the language on the forms, it would not be proper for us to ask for a diagnosis on an extremity case if the legislation goes through as it stands.

Mr Wessinger: I would like to ask you a question with respect to the joints of extremities. You indicated that 5% of chiropractors' cases deal specifically with treatment for joints of extremities. I would be more interested in knowing what percentage of injuries to joints of extremities is dealt with by chiropractors versus the medical profession. Do you have any information on that?

Dr Van Schoor: I do not have the exact number here on total numbers of cases treated by chiropractors versus physicians, but I think it is somewhere in the neighbourhood of between 10% and 20% of all work injuries treated by chiropractors.

Mr Wessinger: That would be overall, but generally, do you find more—

Dr Van Schoor: As to the overall incidence of extremity problems versus back problems, back problems contribute about 28% of our cases, both upper and lower extremity each a little less than 25%, at the time of injury. The distribution is fairly equal between back and upper and lower extremities.

Mr Wessinger: Obviously, physicians would have much more dealing with treatment of extremities.

Dr Van Schoor: Extremities, yes.

The Acting Chair: Thank you very much for your presentation.

1110

MINISTRY OF EDUCATION

The Acting Chair: Now we will move on to the Ministry of Education; we have Julie Lindhout and Deborah Goldberg. Welcome, and I guess we are all set for a few words.

Mrs Lindhout: I am Julie Lindhout, director of the legislation branch of the Ministry of Education. I would like to thank the committee for inviting the Ministry of Education to come before the committee to present our concerns regarding Bill 43. I can do so quite briefly.

The objective of the Ministry of Education is to help individual learners to achieve their potential regardless of their intellectual, physical or emotional situation, in a setting that is best suited to their particular needs, and to prepare them to participate in society to the greatest extent possible.

The ministry has a policy of promoting early and ongoing identification of children's learning needs. Each school board is required to have approved and in operation, as of September 1981, procedures to identify each child's level of development, learning abilities and needs and to ensure that educational programs are designed to accommodate these needs and to facilitate each child's growth and development.

These procedures are part of a continuous assessment and program planning process which should be initiated when a child is first enrolled in school, or no later than the beginning of a program of studies immediately following kindergarten, and should continue throughout a child's school life. As a result of this policy, a broad range of professionals now works with students, and the progress of all students is carefully monitored.

When special assistance or remedial measures are necessary, they should be identified and provided at the earliest opportunity, preferably in an informal, unobtrusive, easily accessible manner by people who are familiar to students in the educational environment.

Students often feel more comfortable if the assessment or counselling is done by teachers, guidance counsellors, or other board staff who are not health professionals regulated under Bill 43. They are more likely to bring their needs to the attention of people with whom they are in regular contact and who can assess their needs and recommend strategies with the least delay or interruption of the education program.

In some circumstances, students are more inclined to discuss problems with clergy, native counsellors, attendance counsellors and others who visit schools on a regular basis. There may be situations where students and their parents

are reluctant to seek professional help but may be persuaded to do so after assessment by, and upon the recommendation of, a teacher or guidance counsellor with whom they feel comfortable.

There may also be situations where professional assistance is not accessible, and the alternative would be no remediation for lack of assessment, or assessment delayed beyond the ability to provide timely remediation. This might occur in remote locations or in inner cities where the parents do not speak English or French. In either of these possible scenarios, the school is the students' main point of contact, and it might be the most appropriate provider of assistance, at least in the first instance, where identification of the existence of a problem is critical.

We are concerned that clause 26(2)1 may have a detrimental effect on the ability of the school system to meet its overall goal of providing an appropriate education to all students, and may inhibit the ability of teachers and other professionals to perform their responsibilities.

Our position was outlined in the letter from our deputy minister, Robert Mitton, which was already brought to the attention of this committee. We note that the basket clause referred to in that letter has been dropped. Our concern with the definition of "diagnosis" remains. It could, however, be alleviated if the act were amended to clearly restrict the prohibited activity to physicians and certain other medical care givers.

Any such amendment should make it clear that the act does not restrict the activities of educators and others who deal with children in a school setting, in a counselling relationship, whether formal or informal. In this way, the overall objective for education can continue to be met.

Our original position, as expressed in the letter from the deputy minister, was that our concern might best be addressed with the regulation exempting education professionals from this act. However, following discussions with Ministry of Health staff, we now believe that an appropriate amendment to the definition of "diagnosis" will alleviate our concerns, and we would be pleased to consult with Ministry of Health staff on this issue.

I would also like to point out very briefly that following the introduction of Bill 82 in 1980, the special education legislation which brought a large number of students with ongoing need for health support services into the regular school system, the ministries of Education, Health, and Community and Social Services jointly agreed on the provision of health support services in school settings. As a result, responsibility for the direct provision of these services at the local level is shared by the school boards, the home care program of the Ministry of Health, and the agencies operating under the Ministry of Community and Social Services.

Specifically, the school boards are responsible for the administration of oral medication, where such medication has been prescribed for use during school hours. For physically disabled pupils, the school boards are to provide such services as lifting and positioning, assistance with mobility, feeding, toileting and general maintenance exercises.

Boards also continue to be responsible for necessary speech remediation, correction and rehabilitation programs.

Paragraphs 26(2)5, 6 and 8 may have implications for this agreement. Our ministry would be pleased to work with the other two ministries to analyse these implications. Thank you again for providing us with this opportunity to express our concerns.

Mr Jackson: I appreciate the presentation and that active discussions are under way, but I am trying to sense—I will ask the parliamentary assistant and/or legal counsel. Can you advise the committee if amendments have been drafted in accordance with the discussions that have just been set out, or are we still discussing what the nature of those amendments are?

Mr Wessinger: I will say that there will be certain amendments coming forth, but they are not yet drafted. The committee will have to assess those as they come forward.

Mr Jackson: Given that you have entered into discussions, can you at least share with the committee what the nature of those amendments is and the current thinking?

Mr Wessinger: I think it is quite clear that the position of the ministry has always been that the matter of assessment and communication of assessment has not been included as a controlled act under the legislation. I do not think the amendments were particularly necessary to set that out, but I think it would clarify it.

Mr Jackson: I appreciate your opinion, but we are talking about substantive legal matters dealing with schools. I recognize that you can do all the assessment you want with a child, but as soon as you put in his OSR that you have modified his program, you have gone through the process of diagnosis under the law and are now implementing a change in the child's program. All of this is done in our schools routinely. So you may not say that there was a diagnosis, but you cannot have an assessment and then move to a treatment in a classroom setting, or any behaviour modification, without having gone through the three steps.

So if I might ask legal counsel—not the opinion of the parliamentary assistant—what is the level of discussion on amendments to address the points that have been raised not only by the deputy minister and the teachers' federations, but now still ongoing concerns that have been shared with this committee by the deputants from the ministry who are before us?

Mr Wessinger: The only thing I can reiterate is that our position is different. In our opinion, we say the Ministry of Education is wrong in its opinion with respect to the legislation. But I will ask counsel to reply to that as well.

Ms Bohnen: I think we are talking about several different things, and I would like to address them separately. First of all, with respect to the agreements the Ministry of Education has entered into with Health and Community and Social Services, I believe, concerning the provision of some health services to disabled students, I would like to remind you that there have been government commitments to an exception for assistance with what we call routines of daily living, including things like toileting, administration of medication by injection and so forth, and that exception would apply to wherever the service was provided, whether it is in the workplace, in the school, in the home. The only issue I think outstanding with respect to that

whole matter is where the exception should appear, in the statute or in the regulation. I believe the concern expressed about those kinds of services specifically has been met, and if that has not been fully communicated to the Ministry of Education, I think we regret that and will be happy to elaborate on it with the Ministry of Education.

Second, with respect to the issue of diagnosis-assessment, I would like to refer you to Deputy Minister Barkin's response to Deputy Minister Mitton wherein he explained his view of why the specific controlled act concerning the conclusions identifying diseases, disorders and dysfunctions would not in any way hamper relationships and communications between education professionals and students.

I would also like to remind you that the minister said, when she came before this committee on the first day, that she hoped to be guided by the committee in terms of amendments to that controlled act. She tried to give greater comfort to the Ministry of Education and to others that this is what we are controlling, not that.

I do not think you can jump to the conclusion that because a notation is made in the school record and a course of action noted there vis-à-vis that student, there has been a clinical diagnosis of a disease or a disorder. I think they are talking about quite different things. I mean, the school record is not going to communicate to the student the fact that the student suffers from a disease. It may note that the student has a disease, but that is certainly not going to be the first communication to the student that he has a particular disease. Surely the plan within the school for assisting the student focuses on things quite different from, "What disease or disorder does this student have?"

1120

Mr Jackson: We are talking about neurological dysfunction in many cases here, not diseases. Diseases are the easy ones to deal with. It is the neurological dysfunction which manifests itself in difficulties in the school setting. These can be complex and these are routinely assessed and routinely treated.

If your position is that there is no diagnosis, then I submit that children are at high risk. What we are hearing from the professionals in the classroom and through school boards is that they are diagnosing to a degree and that they are implementing program modifications.

But the committee gets a clear sense of the position of legal counsel and the government in this matter. I am distressed to hear that you will be dealing with these matters, to the extent that you are prepared to deal with them, in the context of regulations and not within the legislation.

Ms Bohnen: I did not say that.

Mr Jackson: I do not think it is as simple as disease. I think we are dealing with very complex neurological matters.

Ms Bohnen: To the extent that we are dealing with very complex neurological matters, then I suggest to you that the appropriate diagnostician of those matters is a psychologist or a physician. However, if we are talking about the fact that a student has an assessed difficulty in speech requiring certain remediation, then nothing in this legislation of the government inhibits that from taking place, whether

it be by a speech-language pathologist or any other personnel the school boards employ for that purpose.

Mr Jackson: Not to prolong this, my final comment is that if we are wrong and if you are wrong in your assumptions, then the effect will be that less assessment will be going on because of the limited access to the kinds of professionals we now know will be required under the legislation. The school boards do not have these kinds of resources and access points in place, yet they are responding to need in the best way they can. If this all has to do with "harmless" and responsibilities as the legislation sets it out, I am still not satisfied, as I am sure the teachers' federations are not, that those matters are being adequately addressed. That was my final say on the matter. We will revisit this during the amendment process.

The Chair: Question, Mr Bradley.

Mr Bradley: Not being a regular member of this committee—

The Chair: You are a welcome addition to it. I know all members are happy to have you.

Mr Hope: Not all of us.

The Chair: We have a dissent on the comment of the Chair, so Hansard will duly note it and we will continue with the question.

Mr Bradley: You always preambled when you know your question has probably been asked by five other people at some other time who have a detailed knowledge of the bill, but it is a general question; Mr Jackson has made a reference to it. What specific liability is faced by members of the teaching profession who are performing semi-medical duties? The bill obviously is going to define what is a medical responsibility or a medical act and one which is not. I do not know where toileting fits in. I am not trying to be funny, but I do not know where it fits in, for instance. What kind of liability do members of the teaching profession face at the present time?

Ms Goldberg: Do you mean if this legislation is passed?

Mr Bradley: Before the legislation comes into effect, what kind of liability do teachers face who perform certain of these duties at the present time, which they do?

Ms Goldberg: Presumably, as long as they perform them correctly, there is no liability. If there were an accident of some sort, then presumably it would be a civil suit that could be launched by the family of a child who was injured. But I presume that as long as the procedures are administered properly, then no liability ensues.

Mr Bradley: And if there were a suit, it has to be determined by a court whether the procedure was properly performed. Of course, the teachers then would have two concerns: one, that they would be performing any duty of this nature in the first place; second would be that if they are performing it they have adequate information and training as to how to specifically carry out a procedure.

In this bill itself, what will the liability be if the bill were to pass in its present state? What problems are created or which problems are solved?

Ms Goldberg: Criminal offences are created in the bill, and there are very heavy fines that can be imposed as well as criminal convictions.

Mrs Lindhout: Could we also point out that it is not only teachers who are performing a lot of these acts. In many schools it is not teachers; it may be aides, it may be other members of the staff who are involved in these types of activities. The schools generally operate on the basis of whoever is best suited to meet the needs of a particular child, because there is a relationship or something, a comfort level, or perhaps a physical ability to deal with a particular student.

Mr Wessenger: I would like to have counsel address some clarification items in this regard.

Ms Bohnen: This legislation does not address civil liability in any way. It does establish penalties where individuals perform controlled acts, and those penalties are essentially the same as exist today for practising medicine without a licence. But just as there are mechanisms whereby medical acts may be delegated down to non-professional personnel, including teachers' aides, nurses, etc, so does this legislation. Of course, if something like catheterization, as an instance of toileting, were performed under the proposed legislation, it would be sheltered by the exception to which the government is committed.

Mr Bradley: It is not hard to tell I have been out of the classroom for 14 years, because we did not have teachers' aides and others on staff to do things at that time.

1130

Mr Hope: I am trying to get an understanding of where Mr Jackson was coming from on the issue he questioned about. The teachers perform, probably, "on the order of." Inserting medication or helping a disabled person in a classroom, they are acting on an order already. When they do an assessment, they are not actually making diagnosis, so the assessment aspect can still continue as if, as the social worker under the Ministry of Community and Social Services who was here before said, providing a service outside the health institutions or health care model.

I am just trying to get a better understanding, and you got me confused when you answered Mr Jackson. It is not that they are not making the initial diagnosis of the individuals, but what they are doing—I am trying to put this in perspective of what was told to us yesterday by Alan Schwartz—is getting to the root cause of things. This is where I am trying to put what you said today and what Alan Schwartz has said; that they are getting to the root problem is where everybody is up in arms.

Ms Bohnen: You are right, they can continue to assess. There are causes that refer to specific medical conditions, medical diseases and disorders, and the Ministry of Health's view is that medically trained people are qualified to diagnose those conditions. But there are other kinds of causes and descriptions of situations that families, children and students display in the classroom, for example, a misbehaving child. Of course, the teacher must assess in education terms and in behavioural terms the cause of that child's misbehaviour and arrive at a way of dealing with it, but that is not to say the teacher would diagnose that child

as having a brain tumour. I do not see a problem, and Alan Schwartz yesterday did not see that there was a problem.

Mr Hope: But it would be in conjunction with the medical profession. It will not be independent by a school to make all these assessments and diagnoses, but it will be a combination of the medical model, whether it be a physician or a—

Ms Bohnen: I think there are overlapping models. Take the child who is behaving in a strange way in a classroom. The teacher and the guidance counsellor and other resource people in the school have the training and the experience to know when they are dealing with something that they can deal with on their own. But I am sure they also know when they have a child—I hope our guests will correct me if I am wrong—whom they realize needs to be seen by a physician because what is troubling this child goes beyond their expertise. They would not try to make a medical diagnosis and substitute for a physician, but within their own competence, they would analyze the nature of the child's difficulty and respond to it. For that we use the word "assess" and say, "Continue to do it."

Mr Solá: I think I understood you to say that there is a reluctance on the part of some students and parents to seek professional help. Then I guess the question is, how do you influence them to do so, and is the referral to professional help somehow taken as some sort of medical assessment? Is that what you are afraid of?

Mrs Lindhout: Our main concern actually is that the school board staff, teachers and others, will be afraid of that and therefore not begin to do the kinds of things that would lead to a successful referral to a medical professional. There are in fact situations involving children from backgrounds where parents speak neither French nor English, where they are very reluctant to seek the kind of professional or psychological or psychiatric assistance they perhaps should be seeking for their children. The teacher, if that teacher or someone else in the school system gains the confidence of the parents, can sometimes eventually persuade them to do that. But that process might be interpreted by some of the staff as falling under the controlled act, and that is why our main concern is that the situation be clarified specifically in the act so there are no misgivings, no doubts and no concerns on the part of school board staff.

Ms Haeck: I am not sure if you have had a chance at the ministry to look at some of the proposed amendments put forward by the individual professional groups. What you have laid out in your original presentation is the fact that obviously teachers and teachers' aides and other people employed by the board are performing functions which some professional groups feel very strongly should be their province. Could you give me some of your thoughts on what would happen if those amendments were reflected in the proposed legislation?

Mrs Lindhout: We have not had the opportunity to look at any specific proposed amendments.

The Chair: Thank you very much for your participation. Are there any comments from the parliamentary assistant or ministry staff?

Ms Bohnen: You spoke of your concern or misgivings about the extent and application of the controlled act which might deter teachers from the kinds of interactions that would be beneficial and quite permitted. It strikes us that no matter what the format of this legislation is in the end, a number of consumer groups have said there is a need for public education so the public understands what it means, what their rights are and so forth. Perhaps there is also a need for education of education professionals so they can be comfortable with the impact this may have on them and their role. Do you have any comment on that?

Mr Jackson: This is legislation by placebo.

Mrs Lindhout: As legal counsel just pointed out, it is the judicial implication of the legislation that is not clear. If that were clarified, we would be able to work with the Ministry of Health or on our own to prepare the information and communicate it to school boards. We have a good mechanism for doing that.

Mr Jackson: Just for clarification, I get the sense from what I am hearing teachers tell me that it is a case—maybe legal counsel can respond to this—where a child is assessed or diagnosed, however you call it, by a teacher—

The Chair: No, there is a significant difference, Mr Jackson.

Mr Jackson: Okay. In a classroom setting a teacher draws some conclusions based on her observations and can do one of several things. If there is not a great lineup she can bring in a psychometrist or a speech-language pathologist or speech-language therapist, someone who can do further assessments and then potentially do a diagnosis. But if the referrals are one-year waits, maybe year-and-a-half waits—and in many cases they are—the school board is obligated if in its best opinion the child's program must be modified. If I am hearing and understanding the concern in the classroom, that classroom teacher, regardless of all the education we can give them about this legislation, is fearful they will not start program modification until that year down the road when the child can be seen by the competent professional to do the diagnosis and confirm the adjustment in the child's program.

Today in Ontario, the reverse is occurring. There is program modification and observation. That is the concern I believe the teachers are trying to express to us and that the ministry is trying to articulate, that there will be delays, not because the school board is not inclined to come to a conclusion, make a diagnosis and implement program modification, but rather that the legal counsels in the various school boards will advise them when asked that teachers cannot make those program adjustment changes until, in accordance with this legislation, the competent professional prescribes, based on a diagnosis, that program modification.

The Chair: Interrogative?

Mr Jackson: You did say comment or question. Thank you, Madam Chair.

The Chair: And I would just point out to everyone that you are making a speech. That is okay.

Mr Jackson: No, I am not. I am very clearly laying out the concern, because I do not want to hear the word

"disease." These are not diseased children, these are children who have some anatomical or neurological dysfunctions which require assessment and diagnosis and treatment, which we call in schools "program modification." So that is the scenario and that is what I think is the area of concern, and that is what I am sensing will be the outcome. End of speech.

The Chair: Thank you for your comments, Mr Jackson. I call on the parliamentary assistant, who wishes to comment.

Mr Wessinger: I am going to have counsel comment, but I think we should remember this legislation deals with health care and not educational services. With that, I will turn it over to counsel.

1140

Ms Bohnen: That is the first point I would have made. To refer to the example you were providing, which I think had to do with children who undergo psychometric testing prior to a determination of what changes in program or approach are needed, that is a good example because—I hope I do not get into hot water with our Ministry of Education guests—it is not the case that every classroom teacher applies, administers and interprets psychometric tests. Am I correct in saying that?

Mrs Lindhout: Yes, you are correct, but it does occur.

Ms Bohnen: It does occur, but it is not the norm.

Mrs Lindhout: No.

Ms Bohnen: The norm is that people with specific expertise, either a psychometrist or a psychologist, do this, not classroom teachers. Because it is complex; it requires special expertise to do it properly. But that does not stop any teacher from observing the signs of difficulty a child has in his or her classroom and making changes in teaching approach and program to respond to that child's difficulties. That is an education matter, not a health matter.

The Chair: Thank you for the clarification.

Thank you for appearing before the committee today. I know you are aware that if there is additional information in light of the concerns or the discussions that you think might be helpful to committee members, or if there is any information you would like to share with us, if you could present it to us prior to or during the deliberations on clause-by-clause we would be very pleased to hear from you.

Those are all the scheduled presentations we have for this morning. I will entertain any comments from committee members at this point. What I would like to mention is that the clerk has requested from all three caucuses all amendments proposed for discussion during clause-by-clause. It would be helpful if they could be submitted to the clerk by Friday of this week, if possible, so that they could be integrated into a package which would be quite comprehensive, and then she could have them ready, bill by bill, as we proceed through.

Mr Wessinger: Bill by bill, or just the first bill by Friday perhaps?

The Chair: We would prefer all bills if possible. If that is not possible, at the earliest opportunity. The clerk would appreciate whatever you have available by this Friday and the rest will follow as expeditiously as possible. I

anticipate, although we have not had formal direction yet from the House leaders, that clause-by-clause will begin fairly soon after the House resumes on September 23. This committee sits, for the information of the public as well as for members in scheduling their time, on Monday and Tuesday afternoon following question period. That is the time that will be dedicated to clause-by-clause discussion.

I am sure there will be a subcommittee meeting to discuss in what order we will go through this. There are some issues to be discussed there, and I know the whips from all three caucuses would appreciate the views of the members as to whether we should deal with it sequentially or whether you would prefer to hold out certain issues for debate and discussion, as has been the practice in other committees.

I am assuming we are not going to begin on Monday, September 23, because it is the first day of the House session, but in fact we will begin on Tuesday, September 24, unless we receive additional notification.

Mr Bradley: Dealing with Sunday shopping.

The Chair: That is the assumption now. You will be notified if there is a meeting on September 23, but I think that is unusual, is it not, to have it the first day of the House?

Clerk of the Committee: No.

The Chair: The clerk informs me that it is not unusual and that we should assume that we could begin on September 23 unless otherwise notified. Members will receive notification, and interested members of the public can contact the clerk's office or there will be a posted notice as to whether the clause-by-clause hearings will begin on September 23 or September 24, as notified. This, of course, will be subject to House leader meetings and discussions. Any comments from members of the committee?

Mr Jackson: As this is our last public meeting, I would like to thank the clerk and in particular the legal counsel, whom I have been giving a difficult time on various occasions.

The Chair: Nobody noticed, Mr Jackson.

Mr Jackson: In my seven years, with the possible exception of one or two education bills, this is probably the most comprehensive piece of legislation we have had to deal with, and I wanted to commend legal counsel. I have not always agreed with them, but I have enjoyed how well prepared they have been for this committee, and that has been very helpful.

I would also like to express the regrets from our caucus that several ministries were unable or unwilling—we will perhaps never know—to attend before the committee to deal with some matters. For those that were available, I wish to thank the ministries for being here when so requested.

The Chair: Mr Jackson's very kind comments about the staff from the Ministry of Health, the office of the Clerk, the research and Hansard people are probably echoed by all three caucuses and all members of this committee. I see all heads nodding, so Hansard will note that.

Mr Bradley: Some are nodding off.

The Chair: One further bit of housekeeping, an important matter: The next summary will be distributed to members' offices later today or tomorrow. That is a message from our very able research assistant, Alison.

Mr Burrows: There is one submission that we promised yesterday which unfortunately has not arrived. We found a typographical error in it at the last minute.

The Chair: Is Mr Jackson going to take his comment back in light of this new information?

Mr Burrows: It will be given to the clerk within the next day or two.

The Chair: We appreciate that.

Mr Jackson: I am quite confident that legal counsel do not do their own typing.

The Chair: It is always good to have a little humour about these matters.

The standing committee on social development now stands adjourned. It will reconvene upon notice for clause-by-clause.

The committee adjourned at 1147.

CONTENTS

Tuesday 17 September 1991

Regulated Health Professions Act, 1991, and companion legislation / Loi de 1991 sur les professions de la santé réglementées	
et les projets de loi qui l'accompagnent	S-803
Ministry of Community and Social Services	S-803
Workers' Compensation Board	S-808
Ministry of Education	S-811

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S-26 1991

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Standing committee on social development

Regulated Health
Professions Act, 1991
and companion legislation

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Le lundi 23 septembre 1991

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent



Chair: Elinor Caplan
Clerk: Lynn Mellor

Présidente : Elinor Caplan
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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 23 September 1991

The committee met at 1543 in room 151.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

The Chair: I would like to welcome everyone this afternoon. There are a couple of small housekeeping items. Alison, you wanted to make some comments regarding the package from legislative research.

Ms Drummond: All the committee members last week should have received the second interim version of a summary of recommendations by witnesses. This covers everything we heard in committee and a substantial chunk of the things that were received by mail, so the final version will include everything received by mail up to September 4. Ordinarily research does not attend clause-by-clause, but if any research questions come up, Lynn can always reach me by phone. So I will depart.

The Chair: Before she leaves, does anyone have any questions of Alison? On behalf of the committee I would like to comment on what an excellent compendium of recommendations we received. I know we will be looking forward to the final summary, but I would like to thank Alison and the research staff—Bob Gardner was here as well—and compliment them on an excellent piece of work.

Thank you very much, Alison. You will be hearing from us if there are any questions through clause-by-clause.

On the question of information received and questions asked, I think all committee members may be aware of a communication dated September 17 from the Association of Hearing Instrument Practitioners of Ontario, wherein a question was asked regarding Mr Schwartz's presentation. I took the liberty of asking Mr Schwartz to respond to the question that was raised. Mr Schwartz also agreed that if the committee has additional questions of him, he would be willing to respond in writing. I just mention that for the interest of committee members and any members of the public who are monitoring these hearings.

The committee can have Mr. Schwartz's input on any question which was not addressed during his presentation, which is on the record in Hansard. This further information from him can be received by all members of the committee. I will ensure that this happens if I receive anything from him. Similarly, if members have any requests that they would like Mr Schwartz to respond to, I would be pleased,

through the clerk, to undertake to get that information for them and then distribute it to them. That was one piece of housekeeping.

The next thing I want to mention is that the clerk has advised me that a comprehensive package of all the proposed amendments will be ready for tomorrow. It will not be ready for today. That will enable all members to see what is being proposed from the different caucuses, and we will have that available for the public tomorrow as well.

Mr J. Wilson: I think you said the clerk will be presenting all amendments tomorrow. That is certainly not the case with the Ontario Progressive Conservative caucus.

The Chair: All amendments that have been received to date will be available tomorrow for distribution in a comprehensive package where everything has been collated according to section.

Mr J. Wilson: Thank you. I just mention that because Mr Hope was commenting earlier on how thin our package of amendments was. I just want him to know that it is in no way the final list.

The Chair: Just for the information of all members and for the public monitoring these hearings, amendments can be received throughout the course of clause-by-clause discussion. I will repeat it again tomorrow. At no time should anyone assume at any point during the hearings, until the bill has been fully debated and reported, that all amendments have been received. Amendments can continue to be received and tabled throughout the course of clause-by-clause debate.

It has been agreed that we will begin today's meeting with opening statements. I would like, first, to call on Mr Wessenger, the parliamentary assistant.

Mr Wessenger: Good afternoon, members of the social development committee. Public hearings have enabled you to hear from most of the groups who have been contributing their input to this legislative package over the course of the past eight years. It is hard to think of a legislative package that has had more input from interested groups than this one. You have heard the arguments and the recommendations. Now you must analyse the presentations and written submissions—as the minister, myself and ministry staff have—by applying one key test: How would their proposal or suggestion better serve the public interest? Alan Schwartz also brought the importance of this point home to us in his presentation.

We at the ministry are satisfied that the bills, with the amendments we will be discussing over the next few weeks, will well serve the public interest. We believe they will do so better than the existing legislation. We also believe there is no alternative legislative model that could better do that job of meeting the public need to have a louder voice in how the health care system operates and evolves,

to have a greater say in the quality of care they receive, and to see women take a more equal role with men in the management of the system.

The government is proposing a number of amendments. These were delivered to the clerk of the committee on Friday. These are in addition to the ones we provided to the committee and publicly circulated before committee hearings began. Proposed amendments concerning health professions acts will be provided shortly. Amendments addressing the regulatory system in relation to aboriginal peoples will also be moved at a later date.

As to the amendments we are proposing now, I would like to outline the purpose of the most significant ones as a prelude to clause-by-clause discussion. The issue this committee has had the toughest time grappling with is the controlled act in paragraph 26(2)1 of the Regulated Health Professions Act, restricting to certain regulated professions the communication of conclusions about diseases, disorders and dysfunctions. It is the issue that has dominated the hearings.

1550

The government has listened carefully to the fears expressed by clergy and others about the effect of this controlled act on their ability to function. We have also paid close attention to Alan Schwartz's compelling presentation about the paramount importance of protecting the public. We are introducing amendments to the controlled act which we believe will make it clear that the intent is to prevent harm that may result from the communication of diagnosis. The amendment makes it abundantly clear that communication of results of assessments by regulated and unregulated practitioners is not restricted. We also proposed to delete the word "dysfunction" from the controlled act but retain "disease" and "disorder." This amendment will result in consequential amendments to the authorized acts of a number of health professions.

I have an amendment creating a statutory exception so that individuals with disabilities can receive assistance with their routine activities of daily living. This government and the previous one were committed to such an exception from the beginning. However, the issue was whether it would be in the act or regulations. Thanks to interest groups and their efforts in meeting with us to discuss the issue, it is possible to propose a statutory exception which they have informed us meets their need of being able to continue to take part in community living with dignity.

On August 28, the Task Force on Sexual Abuse of Patients made a presentation to the committee. In her statement in the House on the occasion of second reading of these bills, the minister said that the Ministry of Health would have a zero-tolerance policy, as was also declared by the College of Physicians and Surgeons of Ontario. She said it was her goal "to enact a law that will deter sexual abuse, bring abusers to justice and treat victims with greater sensitivity and respect." The government is anxious to take all necessary action to eliminate sexual abuse. Indeed, as is evidenced by the advocacy and consent to treatment legislation, the government is determined to ensure that every individual, no matter how vulnerable or disadvantaged, is served by the Regulated Health Professions Act.

We believe we can take some action immediately. I will outline that in a moment.

As to whether it will be necessary for further action that would be beneficial and appropriate, we believe we must await the final report of the task force and its presentation to the College of Physicians and Surgeons of Ontario. We say this even though the chair of the task force has told the committee that the concept of the preliminary recommendations will not be changed. It is necessary and appropriate to wait, because the task force was created by the college and we want to hear the college's response to the report. Moreover, we want to take action on all regulated health professions and we cannot do that without hearing from them. Furthermore, some of the preliminary recommendations raised contentious Charter of Rights and natural justice issues requiring full discussion with legal experts and the Ministry of the Attorney General.

So immediately upon release of the final report, now scheduled for late November, an interministerial working group will conduct a consultation with all interested professional groups and public interest groups. We hope a consensus will emerge from this consultation, though we recognize it may be necessary to make unpopular decisions and we are prepared to do so.

At this time, we are proposing amendments to the duties of the minister and the objectives of the colleges to reflect their responsibilities and to try to ensure that every individual can avail himself or herself of the rights and benefits of this legislation and that individuals are treated with sensitivity and respect.

We are proposing the creation of a new statutory committee, the patient relations committee. Within one year of proclamation of the bills, we will be requiring every college to institute a program aimed at preventing sexual misconduct. The effectiveness of each college's program will be evaluated by a monitoring board composed of members of the public and representatives of the professions. The monitoring board will be required to make an annual report which must form part of the annual report of the college that is tabled in the Legislature.

RHPA and the procedural code currently include provisions that will improve complaints and discipline processes, such as increasing the number of public members on discipline panels, opening the record of the complaint investigation to the complainant who seeks a review of the decision and opening discipline hearings and protecting the privacy of witnesses testifying in relation to sexual misconduct in discipline hearings. In addition, we are proposing an amendment now to make it clear that a complainant in a discipline hearing may remain in the hearing room during the hearing, even if the general public is excluded, in order to protect the complainant's privacy.

As well, more action will be taken in regulations to be made under this legislation in the definition of sexual misconduct and in standards of practice. Mandatory reporting rules for members may also be addressed through regulation. In the interim, while we await the proclamation of this legislation, we will be formally requesting every governing body that currently exists under the legislation to develop a sexual abuse plan now, and to file it with the minister.

The colleges will be requested to consider what action can be taken immediately and what policies and procedures can be changed or put in place to start the task of eliminating sexual abuse. These plans may form the basis of the sexual misconduct programs to be required under the legislation. Our message is unequivocal: Sexual impropriety and abuse will not be tolerated.

The amendments being provided do not include amendments addressing issues raised by the Union of Ontario Indians, Equay-Wuk and other first nations. The issues that have been raised by aboriginal groups must be addressed in the context of the government's commitment to native self-government. There will be many health care issues to discuss as we move down the road towards self-government. We will be discussing these issues on a government-to-government basis and more agreements will emerge from these discussions.

The particular issue before the committee is how to address the effect of this legislation on native healers and midwives, in the knowledge that these bills are likely to become law before self-government is achieved. There is no pat answer to this question. Clearly, it must be found in consultation with native groups.

The Ministry of Health conducted a first round of discussions with native groups in July and funded initial consultations within their community. The message from every group is that further discussions are required, and we agree with this. At the same time, we are actively considering a range of statutory options, including an option suggested by the Chair of this committee. I know we all want to incorporate into this legislation provisions that will demonstrate respect for traditional healing and enhance the self-determination of native communities. The minister intends to come back to this matter later in the clause-by-clause process.

As I said earlier, we intend to propose amendments to the health professions acts, and they will be provided in the near future. They include adjustments to the scopes of practice and authorized acts of several professions; an amendment to make the performance of an authorized act without a necessary order or direction a disciplinary matter to be dealt with by the profession's college, but not a provincial offence; an amendment to the Nursing Act to reflect the fact that in many circumstances nurses provide care in accordance with their own judgement and not on the order of a physician—similar amendments will be made to certain other health professions acts—an amendment to all health professions acts expanding the range of the provisions restricting the use of professional titles. The restrictions will apply in all settings and will not be restricted to health care.

To sum up, we are now proposing a large number of substantive amendments. Unless there is a clear direction or consensus emerging from the committee, we hope that this legislation would adhere to the bills as tabled.

Issues that are not yet resolved the minister intends to refer to the future Health Professions Regulatory Advisory Council. One such issue is the question of whether registered nursing assistants should continue to be regulated together with registered nurses by the College of Nurses of Ontario or have a separate college. In that context, their

scope of practice and authorized acts will also be discussed. We will be consulting with registered practical nurses and the Registered Nurses' Association of Ontario concerning the terms of reference of referral.

The scope of practice and authorized acts of naturopathy will of course be considered by the advisory council. The advisory council will also be providing advice on scope of practice and on the controlled acts, and on the professions not included in this package which we know will be seeking regulations. Other issues requiring referral may emerge during clause-by-clause.

1600

I mentioned that regulations to be made by the college councils under this legislation will include definitions of sexual misconduct. We want to stress the importance of regulations. They are of no less importance than the statutory provisions themselves. We believe that the review of proposed regulations by the advisory council, which also provides a vehicle for public input, will ensure that regulations are in the public interest. For this reason we feel safe in using regulations, not acts, as a means of fleshing out what misconduct means.

In closing, I would like to take this opportunity to thank the members of all parties for their thoughtful questions and comments and their non-partisan approach to this committee process. I would especially like to thank the Chair for her very effective chairing. I am confident that the spirit of collaboration among committee members, which has been apparent to me throughout the hearings, will continue throughout clause-by-clause.

The Chair: Opening remarks, Mr Beer.

Mr Beer: Thank you very much, Madam Chair, and thank you to the parliamentary assistant for his comments. As was noted, we have just this afternoon received the amendments, so I am not going to comment on those. I think we are going to have to look carefully at those, as well as the ones presented by the other parties, to see how we will proceed with those amendments, but I would like to take this opportunity to make a few comments by way of beginning the discussions and, in some respects, to echo the comments that have been made.

I think all of us on the committee, as we have said, have learned about parts of the body we did not know existed and that there are people out there who do things to those parts of the body, and this has expanded our scope of knowledge.

Mr Owens: Our dinner conversations.

Mr Beer: There were a few times after lunch, when if I had to look at another audio-visual presentation, I may have had some difficulty. But I think the importance of these hearings was underlined by the fact that all of us on the committee, who really are a group of laypeople, found in virtually every presentation something new, or a new perspective on a particular issue or problem.

The first thing I want to do is thank very much all those groups and individuals who came before the committee. Even if in some cases we are not going to be able to deal with every single point that was raised, I think we now have the issues on public record. It has been said that we have, through this legislation, an ongoing mechanism

to deal with many problems. I want to thank all those who spent so much time in putting together their presentations and making them.

I also think it is appropriate at this point to thank the staff from the ministry, our own research and people, the clerk. Again, in a committee such as this, the amount of material we had to receive and examine is really quite incredible. A number of people helped us to work our way through it, and now we really are ready to look at the legislation on a clause-by-clause basis, beginning with the omnibus act.

Clearly, the key issue and the one on which it was important that we spoke with Alan Schwartz at the end of our review, after having gone through many of the specific and particular issues, is that of the public interest. In a sense, as members of this committee, as laypeople, that is the measurement, if you like, we need to try to put on each question we are going to be examining and each amendment we will be looking at.

It has been noted many times in the course of the review, and in terms of what we are trying to accomplish, it is to protect the public interest and to provide for greater access to an ever-increasing number of health care services. I think that has been admirably done by the review and we will now be able to use the legislation in place to keep at it, if you like. I have stressed this with many people: It does not end with the proclamation of Bill 43 or any of the other bills, but in fact it has really set in motion a particular process that I think is going not only to enhance the health care that is available but also to ensure that it will be even better than it has been.

One of the things that struck me, particularly with those professions which for the first time will be receiving a college, was their own sense of wanting to ensure that they do what they do in an appropriate fashion and meet the scope of their area of practice. That is going to be very good protection for the public. Many have noted that during the course of the review, and particularly over the last couple of years, they have come together to meet with fellow practitioners in other areas. There have been some real benefits where people have perhaps sat down and discussed related areas of health care in a way they have never done before.

A lot of spinoffs have occurred as we have gone through this that are also going to make for a much better system of health care in this province. I am interested in looking carefully at the amendments that were noted, particularly around the diagnosis issue. Clearly, if we go back through all the hearings, the major concern was around this whole question of communicating. I think we as committee members all agreed and the ministry agreed that many things were being done that we did not want to stop being done, but we had to find a way to achieve that while at the same time protecting the public interest. It is in that vein that I think it is going to be necessary for us to still talk about the question of the harm clause and whether some wording is still required that will balance off changes we may come to make in the area of the diagnosis clause.

I was struck by Mr Schwartz's concern about particular changes that might come about and how still to make very clear the protection of the public. Perhaps as we go

through, having these amendments proposed for the purposes of discussion, and certainly in terms of the ones we will be proposing, we want to get feedback, not looking at them as something written in stone, but always measuring the changes. That was one of the points we do not want to lose sight of, that we have a number of bills before us in addition to the omnibus bill and what we do in one has to relate to the basic concepts, the basic principles we are putting forward in that first one, Bill 43. I think that is a discussion we still feel is very important.

Again, we underline and recognize that by this legislation we are not trying to stop social workers from doing what they normally do. We are not trying to stop the clergy from doing what it does. There are a number of people who are concerned. I think we can deal with that while still ensuring that there is some clear indication in terms of what people can and cannot do. We have a responsibility to address that issue. I am very pleased that mention was made of one of the amendments around those with disabilities because I know we all were wrestling with that one. We should note the work that was done by the ministry, by several of the disabled organizations as well as health professionals in a number of areas, in themselves trying to work this out. If we can do that, it will be of tremendous help.

I think we are going to want to look carefully at the various issues raised around the area of sexual abuse, the proposed patient relations committee. Clearly that issue has to be front and centre and, as we move forward with this legislation, we must ensure that we reflect what is increasingly the determination of everyone, to see that we really deal with that specific issue.

Again, as was noted with respect to the native population, we have some proposals that we hope may be helpful in dealing with some of the issues native leaders have raised and we will be sharing those with everyone.

Finally, by way of opening remarks, I stress again one of the concepts we really did not have a lot of time to discuss—and for a very good reason; it is a body that does not yet exist—the advisory council. We should remind ourselves that it is there for a very good and specific purpose, which is to carry on the process we have begun in terms of some of the issues where frankly we as a committee may simply feel we cannot make a final judgement. We just do not feel comfortable. I think that is a perfectly valid argument to use in some instances. If we feel uncomfortable and believe it needs more review, that is one of the reasons that advisory council is there. After we have finished our work, it is to that body the minister of the day will be able to refer a variety of questions. If we look at how it is going to be constituted and the work it will be doing, I think it is not only going to provide protection for the public but, for the professions, a real place to go to see how this new system is functioning and, as problems arise, to help in resolving them.

1610

We dealt with a bill which I think all ministers who have dealt with it have said is not by any means perfect. We have dealt with a bill that was proposed by a review team where the chair of that team said, "Look, it's not perfect, but we have reached a point where it is perhaps as close to that as we can get." With the amendments that we

will discuss, I think we will be able to make it that much better, but undoubtedly there will still be questions which go beyond this committee. I think that, having done this work, the health care system in the province really will be the better for the work of everyone, and we want to keep that front and centre and focus on the public interest as we go through Bill 43 and the other acts that will follow.

So with that by way of opening comment, we will wait for a review of the actual amendments.

The Chair: Opening statement, Mr Wilson.

Mr J. Wilson: Perhaps it is appropriate to begin by thanking you for having put up with us over the summer and chairing our committee meetings.

The Chair: All in favour?

Mr J. Wilson: A raise is in order, I am sure. You have done an excellent job. You have not only provided guidance to the committee but you have provided tremendous insight in informal settings outside the committee. That has been very helpful to me personally and, I know, to other members of the committee, so I thank you.

I would also like to thank legislative counsel. Although we have not always agreed on some of the interpretations and intentions of the wording in the legislation, I am very grateful for their help and to the various ministries that have helped.

On a very personal note, I also thank the PC caucus's sole researcher in this area, Louise Verity, who is with us today. Louise has done a tremendous amount of work. We do not have 108,000 civil servants to help us out. We have one, and she is not even a civil servant, so I am grateful to her for all the work she has done in following the committee and helping the legislators to bring forward amendments.

On a sour note, I am gravely disappointed that the government would not allow us to see its amendments prior to today. I think it was not in the public interest to hold back the amendments. Certainly tradition around here is that the government brings forward amendments first. It has all the legal eagles on staff and it has the larger staff to deal with amendments and to deal with suggestions brought forward by the public, and I am disappointed that we are only now being given the amendments. It would have made for a more fruitful discussion today and certainly for even more fruitful opening remarks by myself had I been able to see the amendments earlier.

We were here on the weekend actually and we had hoped to have the amendments and be able to go over them. That was not the case, and I warned the government that in the future, whether intentional or not, that tends to politicize the legislative and committee process. I just warned the government that it is not good. We went through, in good faith, some four weeks of committee hearings in the summer in a non-partisan fashion, and to find out on Friday afternoon, after meeting with the minister Friday morning, that we were unable to see the government's amendments was disappointing and, I think, set us back a few days.

In fact at the end of my remarks today I will be asking the committee that we adjourn for the day so that we will have some time to look at the government amendments. First, we too have a responsibility, as all committee members do,

but particularly in our caucus, to consult with our caucus. We do not tell our caucus what to do. We consult with our colleagues. Second, we have a number of interest groups and people who have appeared before the committee with whom we need an opportunity to discuss the government's amendments and more of our own amendments.

I am still concerned, having had a cursory view of the government's proposal to deal with the diagnosis clause, that we are not making clear the intent of the legislation, which is that in no way is the legislation to interfere with the normal duties of unregulated practitioners such as mental health workers—the clergy in particular—and social workers. We will be introducing further wording to ensure that it is clear to anyone who picks up the piece of legislation that it is not intended to inhibit the good work that those unregulated professionals do.

I think it is important in this day and age, when we create legislation, that normal, average people do not need a team of lawyers to interpret it for them, that the wording be very clear in the Queen's English that people feel comfortable with legislation when they read it—they should be able to buy it in the Ontario government bookstore and understand the legislation—and that we do not leave a great deal of interpretation up to the courts, which up to this point seemed to be the government's preference.

We have a very legalistic society. The newspapers and media are full every day of stories of the lawsuits that are going on among individuals, between government and groups and government and individuals. It reminds me very much of the California mentality that we used to refer to. It is a legalistic society and it is our responsibility as legislators to have legislation that is as clear, as easily readable and as understandable as possible to the public. We will be doing our best there; in fact, we will be suggesting that there be a preamble in the legislation that clearly states that in no way is this legislation intended to prohibit the good work done by the clergy and other unregulated professions.

Also, the diagnosis clause itself—I did not hear the parliamentary assistant address this; excuse me if perhaps he did and I missed it—there are a number of groups that I think presented compelling evidence before this committee that they should be able to diagnose and communicate within their scope of practice. We will be bringing forward amendments to deal with specific groups where we felt the evidence certainly weighed in on their side, on the contention that they are now diagnosing certain diseases and disorders and they are now communicating the results of those diagnoses not only to their patients but to the Workers' Compensation Board and to other health care practitioners. As I said, we will be introducing some amendments in that area.

Also, I do not think the parliamentary assistant dealt with the area of the powers of the minister. Certainly we had many groups appear before this committee that were very much worried about new powers that the minister is etching out for herself, in this case, which could very well cut into the principle and the intention of this legislation, which is to maintain the principle of self-regulation.

We will also be looking at what we see as further erosion of the principle of self-regulation, and that is the

government's announcement, outside the committee, I may add, to increase the number of public members to just under 50%. I think we can come to a slight rearrangement there that will not erode or provide discomfort for professions. I say to the government that you either believe in self-regulation and you trust these people to be self-regulated or you do not, and you have to come clean with the public on that. I will be looking for a very clear statement from the government on its true belief there because I get the feeling from the government members from time to time that they are suspicious of professionals. I do not want to see that suspicion, which I think is unfounded, rooted in legislation, at least not during my term in office.

We will be looking on behalf of nurses. We are still not satisfied with the fact that the legislation, perhaps unintentionally, has moved to narrow the scope of practice of nurses. We certainly had testimony before this committee that nurses are capable of doing some 60% of what doctors do, and we will be introducing amendments in that area to ensure that the scope of practice for nurses does not inhibit what they are doing now and is flexible enough to provide for any advances that may be made in the nursing profession in the future.

Disabled persons: I commend the government and I am very pleased to hear from the parliamentary assistant that agreement has been found on an amendment that looks after the concerns that were brought before this committee by attendant care providers and recipients of that service.

1620

Sexual abuse: I am very pleased to hear—and in fact when we met with the minister last Friday, we made it very clear that it was one of our very strong beliefs that the government should come out very clearly in support of the interim report by the sexual abuse task force of the College of Physicians and Surgeons. It is very important that we send out a clear message from all three caucuses, and particularly from this committee, that zero tolerance is the law.

I say to the parliamentary assistant, and to the minister through him, that there are some things we can do at this time which I do not think would prejudice the final report of the task force in any way and would indicate our very serious commitment from all three caucuses in the area of sexual abuse and zero tolerance. In fact, in addition to what the parliamentary assistant has said, our caucus is certainly willing and will put forward the concept that was introduced to the committee by the task force chairman, and that is a survivors compensation fund, which colleges would be required to establish. Very often we saw, in the case of physicians in the testimony before the task force on sexual abuse, that physicians had profited from years of sexually abusing patients. I think this committee must send out a very clear signal that this is not acceptable. I do not think we are pre-empting anything that the committee itself will not recommend. The chair appeared before us and gave us a very clear indication of what recommendations will come forward from the final report of the committee.

Just a couple more, I guess. The title "doctor": We have the very strong opinion that since in this legislation we are moving to give the title "doctor" to chiropractors and psychologists, we also have a responsibility to the

academic community to ensure that those health care professionals who have achieved the distinction and the degree of PhD should also be allowed to use the term "doctor" within a health care setting. It is my understanding from having spoken with a number of physicians that there is no confusion now in the hospital setting. The term "doctor" is often referred to by physicians themselves when referring to their PhD colleagues, and I think it is only right and it is a degree of justice that those people who have earned the highest degree possible in academia be allowed to use that title. I do not believe and do not support Mr Schwartz's contention that it will add mass confusion in the health care setting. I give the public more credit for understanding the difference between PhDs and medical doctors than perhaps the review committee did.

Title protection: Certain professions came before the committee to tell us that the legislation is serving to wipe out common usage of their titles, and we will be introducing amendments to ensure that the usage that is out there now that both consumers and health care professions use to refer to the profession is allowed to continue.

The parliamentary assistant mentioned registered nurses and the registered nursing assistants. We will be moving an amendment to establish a separate college for registered nursing assistants, but we are open, of course, to debate on that matter. It is a debate that I think will be fruitful here because there are a number of issues around that. Almost all other provinces have moved towards that now and I think the time is perhaps right in Ontario. It may not have been right some four years ago when Mr Schwartz last looked at this issue, but I think perhaps it is right now, and it is up to committee members to bring ourselves up to speed on the fact that RNAs are ready to have their own college.

I think that is about it. On native issues, we will be bringing forward some amendments for discussion. Again, there may be some areas we can move forward in that would not interfere with or preclude further discussions with natives, but I think it is up to all of us to bring forward a very strong message on behalf of natives that there is an understanding of their plight here at Queen's Park to help them advance their agenda, in fact.

In light of the Premier's commitment to native self-government, I think it is incumbent upon the government to come to this committee and to bring forward amendments that help clarify that for the public. My party has long said that we are not sure what native self-government means. The Premier has yet to define that. We had representations from a native group before this committee. They certainly made it very clear to me that this legislation may very well be their test legislation. It is the first major piece of legislation that has come forward since the Premier made his commitment to native self-government, and I think it is incumbent upon all legislators to have a further discussion of that and perhaps introduce amendments to this legislation which may advance that agenda. We would have no objection to that from our party, as long as it is fully explained to the public. We want to make sure we understand what the terminology is that we are using when we talk about native self-government. This legislation

could very well be the test case, and both in private and public discussions with native groups, that certainly seems to be an intention out there.

Once again, thank you, Madam Chair, for your patience over these hearings and for the indulgence of all members. If I may, I would move that we adjourn the committee. We will have a subcommittee meeting to discuss the process and where we go in the next few days. Certainly we need time on the phones this afternoon and

meeting time tonight to discuss the government amendments, some of our amendments and the Liberal amendments with interested parties.

The Chair: That concludes opening statements. I heard a motion to adjourn the committee at this time. All in favour of adjournment? Opposed? The committee stands adjourned until tomorrow following question period.

The committee adjourned at 1626.

CONTENTS

Monday 23 September 1991

Regulated Health Professions Act, 1991, and companion legislation / Loi de 1991 sur les professions de la santé réglementées
et les projets de loi qui l'accompagnent S-817

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Chair: Caplan, Elinor (Oriole L)
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Haeck, Christel (St. Catharines-Brock NDP)
Hope, Randy R. (Chatham-Kent NDP)
Malkowski, Gary (York East NDP)
Martin, Tony (Sault Ste Marie NDP)
McLeod, Lyn (Fort William L)
Owens, Stephen (Scarborough Centre NDP)
Silipo, Tony (Dovercourt NDP)
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Witmer, Elizabeth (Waterloo North PC)

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Monday 30 September 1991

Standing committee on social development

Regulated Health
Professions Act, 1991
and companion legislation

Chair: Elinor Caplan
Clerk: Lynn Mellor

Assemblée législative de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le lundi 30 septembre 1991

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent

Présidente : Elinor Caplan
Greffière : Lynn Mellor



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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 30 September 1991

The committee met at 1530 in room 151.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

The Chair: I see a quorum. The standing committee on social development is now in session.

We have had our opening statements. We will begin today with section 1.

Mr Owens: Madam Chair, just before we get into this, Frances Lankin, the minister, will be available next Monday to come in to discuss the diagnosis clause, as we had agreed previously, if that suits the committee.

The Chair: So your request, Mr Owens, is that section 26 be stood down.

Mr Owens: That is right, in case by some miracle of process we reach section 26 by Tuesday.

The Chair: That it be dealt with next Monday?

Mr Owens: Yes.

The Chair: Mr Owens moves that section 26 of Bill 43 be stood down and be dealt with next Monday, October 7.

Motion agreed to.

The Chair: The committee has decided to deal with section 26 next Monday, and the minister will be present. Any further motions at this time before we begin with section 1? In that case, we will deal with section 1.

Sections 1 and 2 agreed to.

Les articles 1 et 2 sont adoptés.

Section/article 3:

The Chair: I see that there are amendments to section 3.

Mr Wessinger moves that section 3 of the bill be amended by adding at the end "and that they are treated with sensitivity and respect in their dealings with health professionals, the colleges and the board."

Motion agreed to.

Section 3, as amended, agreed to.

L'article 3, modifié, est adopté.

Section 4 agreed to.

L'article 4 est adopté.

Section/article 5:

The Chair: Mr Jackson moves that clause 5(1)(c) of the bill be amended by striking out "require" in the first line and substituting "request."

Motion negatived.

Mr Jackson: What a shame.

The Chair: Any further amendments to section 5? Mr Jackson, you have an amendment to section clause 5(1)(d).

Mr Jackson: You are very helpful today. Thank you.

The Chair: Mr Jackson moves that clause 5(1)(d) of the bill be struck out.

Motion negatived.

Section 5 agreed to.

L'article 5 est adopté.

Section/article 6:

Mr Wessinger: I would like to ask that section 6 be stood down for further consideration.

The Chair: We have a request from the parliamentary assistant that we stand section 6 down. To the end of the—

Mr Wessinger: Yes, to the end. That would be fine.

Mr Jackson: The complete section?

Mr Wessinger: The complete section, yes.

The Chair: Any questions or comments?

Mr Beer: It is to be stood down till a particular time, or you want to do it at the end?

The Chair: The request, as I understand it, Mr Beer, is that at the end of the rotation of sections, we would come back to section 6. The request to stand down would be until the end?

Mr Wessinger: Perhaps when we get to the whole patient relations matters, we could deal with this at the same time.

The Chair: Which section is that? I would prefer, as Chair, that we be precise; that unless there is a specific request, then automatically, if it is approved, the section will be dealt with at the end. If anyone requests standing down the section to a specific time or a specific point, I would appreciate it if they made that point when we deal with the section, just for clarity.

Mr Wessinger: Could I ask that it be dealt with at the same time as schedule 2, section 81.1?

The Chair: The clerk has recorded that. Agreed?

Agreed to.

Sections 7 to 12, inclusive, agreed to.

Les articles 7 à 12, inclusivement, sont adoptés.

Section/article 13:

The Chair: Shall section 13 carry?

Mr Wessenger: I have an amendment. It is additional, so it will come after section 13.

The Chair: Shall section 13, as printed, carry? All in favour? Opposed?

Mr Beer: I am sorry, Madam Chair, what is it we are carrying here with an amendment?

The Chair: Section 13 as printed, as written. The parliamentary assistant has indicated that there is an amendment to add a new section. The question I have is that there is a government motion here on section 13.1. Is that a new section?

Clerk of the Committee: Yes.

The Chair: Okay, so as written, section 13. Carried?

Section 13 agreed to.

L'article 13 est adopté.

The Chair: We have a new section.

Mr Wessenger moves that the bill be amended by adding the following section:

"13.1 The function of the advisory council is advisory only and no failure to refer a matter or to comply with any other requirement relating to a referral renders anything invalid."

Mr Wessenger: The purpose of this amendment is to clarify that the position of the council is advisory only and that no regulation could be rendered invalid by reason of any procedural problems.

The Chair: All in favour? Opposed?

Motion agreed to.

Sections 14 to 21, inclusive, agreed to.

Les articles 14 à 21, inclusivement, sont adoptés.

Section/article 22:

The Chair: Shall section 22 carry?

Mr Wessenger: I have an amendment.

The Chair: Mr Wessenger moves that the French version of section 22 of the bill be amended by striking out "de décisions" in the third line.

And the rationale? Do you want to put that on the record?

Mr Wessenger: It is an amendment for grammatical clarity.

Mr Beer: Would the parliamentary assistant entertain a question on grammatical clarity en français?

Mr Wessenger: I do not know whether anybody here could give that explanation.

Mr Beer: I withdraw the question.

The Chair: In fact, I think Mr Beer might be able to.

Mr Wessenger: He might be able to do better; that is right.

Motion agreed to.

Section 22, as amended, agreed to.

L'article 22, modifié, est adopté.

1540

Section/article 23:

The Chair: Shall section 23 carry?

Mr Wessenger: I have an amendment.

The Chair: Mr Wessenger moves that subsection 23(5) of the bill be amended by striking out "and, in the case of a complainant review, to the complaints committee" in the fourth and fifth lines.

Mr Wessenger: The purpose of this amendment is that as the complaints committee is not a party at the complaint review, it is incorrect to require the health professions board to share with it the advice it receives in connection with a review.

Motion agreed to.

Section 23, as amended, agreed to.

L'article 23, modifié, est adopté.

Section 24 agreed to.

L'article 24 est adopté.

Section/article 25:

The Chair: Mr Wessenger moves that the French version of subsection 25(1) of the bill be amended by

(a) striking out "objets" in the sixth line of clause (b) and substituting "choses";

(b) striking out "à l'examen" in the second line of clause (c) and substituting "au réexamen" and by inserting "à" after "ou" in the third line; and

(c) striking out "révision de décision" in the first line of clause (d) and substituting "réexamen".

Any discussion on the proposed amendment?

Motion agreed to.

The Chair: You have a further amendment to section 25, Mr Jackson?

Mr Jackson: We will not be tabling our amendment.

The Chair: Withdrawn?

Mr Jackson: Withdrawn.

Section 25, as amended, agreed to.

L'article 25, modifié, est adopté.

The Chair: Section 26 has been stood down by a previous motion.

I would point out to Mr Owens that not only have we reached that section today, but we did so in approximately 20 minutes. I just wanted to point out that miracles can and do sometimes happen, even in the Legislative Assembly.

Mr Owens: I would like to commend the Chair for her speed in getting this bill through.

The Chair: All in favour? Shall we carry on?

Mr Owens: I do have a comment about the translation we are receiving from the parliamentary assistant, however. If we could have some—

The Chair: We will not make any comment on that today, Mr Owens. As we proceed, section 27.

Section/article 27:

Mr Wessenger: I have an amendment.

The Chair: Let me catch up with that. I think there are several amendments to section 27.

Mr Wessenger: No, just one.

The Chair: Mr Wessenger moves that section 27 of the bill be amended by:

(a) striking out "the regulations" in the third line of subsection (1) and substituting "any applicable regulations"; and,

(b) striking out "the regulations" in the second and third lines of subsection (2) and substituting "any applicable regulations."

Mr Wessenger: This amendment is to clarify that any controlled act may be delegated.

Motion agreed to.

Section 27, as amended, agreed to.

L'article 27, modifié, est adopté.

Section/article 28:

The Chair: I believe we have a government amendment.

Mr Wessenger moves that section 28 of the bill be amended by adding the following clause:

"(e) assisting a person with his or her routine activities of living and the act is a controlled act set out in paragraphs 5 or 6 of subsection 26(2)."

Mr Wessenger: This was the amendment which was negotiated with all the interest groups with respect to attendant care services. It is supported by the disabled groups and the Ministry of Community and Social Services. You may remember there was great concern addressed by persons who needed assistance in their daily living because of certain acts that were done within the framework of controlled acts. This is to remedy that situation.

The Chair: Any discussion on that amendment?

Mr J. Wilson: I just point out to members of the committee that we have also introduced an amendment. Unfortunately, it is in section 26. That also deals with attendant care. It is certainly our opinion that our amendment is—I guess to use the word—better than the government's in that it recognizes that a person with a disability and in need of attendant care is in charge of attendant care. We heard a great deal of testimony before this committee that vital to the point of attendant care was that the person receiving the care is in charge of the care. I ask members to consider our amendment in section 26.

The Chair: Section 26 is not before the committee at this time.

Mr J. Wilson: In light of that, Madam Chair, I ask that we stand down this particular clause because it is tied to our amendment. It is going to require a bit of debate.

The Chair: We have a motion that section 28 be stood down and be dealt with immediately following section 26. All in favour? Any opposed? Section 28 has been stood down.

Mr Beer: Madam Chair, I note that there is another amendment which would then be dealt with at that same time. I draw that to members' attention.

The Chair: We have a request from Mr Beer that all amendments to section 28—

Mr Wessenger: There is no reason why we cannot deal with section 28.1, because that is a new section.

The Chair: Okay. We have a new section proposed, section 28.1.

Mr Beer moves that the bill be amended by adding the following section:

"(1) No person, other than a member treating or advising within the scope of practice of his or her profession, shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably foreseeable that serious physical harm may result from the treatment or advice or from an omission from them.

"(2) Subsection (1) does not apply with respect to treatment by a person who is acting under the direction of or in collaboration with a member if the treatment is within the scope of practice of the member's profession.

"(3) Subsection (1) does not apply with respect to an act by a person if the act is a controlled act that was delegated under section 28 to the person by a member authorized by a health profession act to do the controlled act.

"(4) Subsection (1) does not apply with respect to counselling of an emotional, social or spiritual nature.

"(5) Subsection (1) does not apply with respect to anything done by a person in the course of,

"(a) rendering first aid or temporary assistance in an emergency;

"(b) fulfilling the requirements to become a member of a health profession if the person is acting within the scope of practice of the profession under the supervision or direction of a member of the profession;

"(c) treating a person by prayer or spiritual means in accordance with the tenets of the religion of the person giving the treatment;

"(d) treating a member of the person's household; or

"(e) assisting a person with his or her routine activities of living.

"(6) Subsection (1) does not apply with respect to an activity or person that is exempted by the regulations."

1550

Mr Beer: I think there were two particular reasons we wanted to bring this amendment in. One is, members will recall the original clause that dealt with this issue had been removed earlier by another minister, and at that time there had been no real discussion as to the kind of balance we were seeking in this particular area with respect to the risk of harm. What we have tried to do is to meet the concerns that were expressed by people who had concerns about the original clause. Again, the Chair, when she was minister, had suggested that at the committee the committee would deal with this question in trying to find if there was a way of meeting the needs both of the original clause and then of the concerns that have been raised about it.

We bring this forward for discussion with all members, but with the concern that after hearing from all of the witnesses and from Mr Schwartz, in our view there was still a need for a balance with respect to this question of harm. It was our thought that through this we have caught the specific concerns of those who are social workers, those who are in the clergy and others who are counselling. Clearly, we would welcome any discussion of this amendment, but believe it provides a balance that is still required in the act.

I would leave my opening comments on the amendment and, if there are any questions, try to deal with them.

Mr Jackson: We will be supporting the new section, but we had a further amendment to subsection 28.1(4) to read, "Subsection (1) does not apply with respect to counselling of an emotional, social, educational or spiritual nature."

The purpose of that motion, Madam Chair, is to ensure that it is abundantly clear, as was stated during testimony, with examples occurring in educational institutions across this province, that we surely do not wish to entrap teachers and certain counselling activities which are occurring in the classroom and are of a routine nature and required by the Education Act to be in any way seen to be connected. Therefore, we want them clearly stated here as an exemption. I hope the Liberals will consider that as a friendly amendment, but it is certainly one that our caucus is very committed to.

The Chair: Are you prepared at this time to submit that in writing?

Mr Jackson: Would you like me to write out the one word?

The Chair: Yes. You must submit it in writing.

Mr Jackson: It is like school, is it not?

The Chair: This is educational.

Mr Jackson: I left the door open, Madam Chair. If the Liberals would accept it as a friendly amendment, then Mr Beer would have to do the writing out and then I could get to my meeting.

The Chair: I have been advised by the clerk that you must submit it in writing, but we are writing it out for you, to be helpful.

Mr Jackson: What a clerk.

Mr Beer: This is a friendly committee.

Mr Jackson: I did have the spelling correct, I want you to know, in both official languages.

Mr Owens: Just to comment on the initial amendment before the friendly amendment was made, the government will support the initial amendment put forward by Mr Beer. The issues that became clear to me as we heard from deputants across the province were that on one hand they wanted the system to be opened up to try and eliminate some of the hierarchies that have existed in medical practice throughout history, but on the other hand they also insisted that consumers be protected. I think it was the College of Physicians and Surgeons that used the term "cabbage leaf wrappers" as being the folks we would want to protect innocent people from.

I think this amendment protects consumers from, I guess, the best of the worst, if you want to put it in terms of the hit parade. I think Mr Beer has put forward quite a reasonable amendment and has dealt with the kinds of exemptions that were expressed specifically by the unregulated folks. I know there has been some consternation within that community with respect to harm clauses, but I think this not only addresses the safety issue but also addresses the concerns the unregulated practitioners have. I think these people, whether they are in the churches, whether they are counsellors, will be free to practise as they have up to this point.

Mr Beer: I just say to my colleague who moved the amendment to add the word "educational" that it would be quite acceptable to us.

Mr J. Wilson: Certainly we agree with the wording in section 28.1. That does not preclude that we may want to bring in further amendments in section 26, again to address the concerns as mentioned by Mr Owens of the unregulated professionals.

Mr Jackson: It was a good offer from Mr Owens.

The Chair: Any further discussion? We will call the vote first on the amendment to the amendment, as proposed by Mr Jackson, to include the word "educational." All in favour? Any opposed?

Motion agreed to.

The Chair: The motion now on the amendment as placed by Mr Beer. All in favour?

Motion agreed to.

The Chair: There is a section 28.2, which is a new section. I point out that it refers to section 26. Do you want to stand that down? All in favour of standing down discussion of the amendment to section 28.2, to be dealt with immediately following section 26?

Agreed to.

Section 29 agreed to.

L'article 29 est adopté.

The Chair: Mr Wessenger moves that the bill be amended by adding the following section:

"29.1 (1) No person shall design, construct, repair or alter a dental prosthetic, restorative or orthodontic device unless,

"(a) the technical aspects of the design, construction, repair or alteration are supervised by a member of the College of Dental Technologists of Ontario, of the Royal College of Dental Surgeons of Ontario; or

"(b) the person is a member of a college mentioned in clause (a).

"(2) A person who employs a person to design, construct, repair or alter a dental prosthetic, restorative or orthodontic device shall ensure that subsection (1) is complied with.

"(3) No person shall supervise the technical aspects of the design, construction, repair or alteration of a dental prosthetic, restorative or orthodontic device unless he or she is a member of the College of Dental Technologists of Ontario or the Royal College of Dental Surgeons of Ontario.

"(4) This section does not apply with respect to the design, construction, repair or alteration of removable dentures for the patients of a member of the College of Denturists of Ontario if the member does the designing, construction, repair or alteration or supervises the technical aspects.

"(5) This section does not apply with respect to anything done in hospital as defined in the Public Hospitals Act or in a clinic associated with a university's faculty of dentistry or the denturism program of a college of applied arts and technology."

1600

Mr Wessenger: Basically what this amendment does is ensure that the design and manufacture of dental plants, as in commercial dental laboratories, is supervised by a

registered dental technologist and contains the appropriate exceptions for dentists and denturists.

Mr Beer: I just want to make sure I understand this. With respect to subsection 29.1(4), I take it that in that list of designing, construction, repair, etc, the denturist could do all or one of?

Mr Wessenger: Yes, that would be correct. All or one of.

Motion agreed to.

Section/article 30:

The Chair: Mr J. Wilson moves that section 30 of the bill be amended by adding the following subsection:

"(2.1) Subsection (1) does not apply to a person who is a member with a doctoral degree in his or her profession from a university approved, for the purpose of this subsection, by the council of the member's college."

Mr J. Wilson: The purpose of the amendment is to ensure that those health care professionals who have earned a PhD degree may be able and entitled to use the term "doctor" in a health care setting. It is not only a very strong personal belief of mine, but caucus believes that as this committee and this legislation and previous legislation have extended the use of the term "doctor" to other professionals, certainly those who have achieved the highest level of academic excellence, as reflected in the PhD, should be allowed to use the term "doctor" in a health care setting.

We do not believe the public will be confused by this. In fact, in consulting with the College of Physicians and Surgeons, it is my understanding that they do not believe the public will be terribly confused. Mr Schwartz's own rationale in some areas has been that the public will be confused, and other times he has told us that, when it comes to restriction of certain titles, the public are going to have to get used to certain titles that they may not be used to now. That may be the case here. We think allowing PhDs in health care professions to refer to themselves as "doctor" certainly is in order.

Mr Beer: This was a topic that came up at great length, and I know we were all very much troubled by not allowing someone who has a doctorate to be able to use that title. It seems to me that it is not beyond the imagination of the various councils to find a way by which the fact that one has a doctorate can be indicated.

It just does not seem right that we are telling somebody they cannot use a title they have earned in the normal fashion. And this is something whereby, within a health care setting or a hospital setting, different kinds of identification can make it clear that the person is a doctor in this or that profession.

A number of people suggested, for example with speech therapists, that it say, "Dr Anne Smith," and then underneath that, "speech therapist." That is perhaps a way the different councils can find of making sure it is clear what a person has a doctorate in. But for that reason, we would support the amendment made by the Conservative member.

Mr Wessenger: I would like to speak in opposition to the amendment. I think it is very clear that the public would be confused in a health care setting by the use of the

word "doctor" on a title, because in all the presentations made before us it was quite interesting that generally even other health professions, in making comments about the physicians and surgeons, always tended to refer to them as doctors. So I think it is quite clear there would be confusion.

There is nothing in the legislation that prevents a person from showing their degree, their PhD, and there is nothing that prohibits someone who knows what a PhD is from calling a person "doctor" if they so wish. The restrictions now exist in the Health Disciplines Act.

We believe it would create some confusion between members of the public and certain individuals such as audiologists and speech/language pathologists if some of them were called "doctor" and some of them were not. We do not want to create that confusion among members of the public.

This legislation is not designed to create status. It is designed to facilitate designations and avoid confusion among the public. Also, the minister has regulation-making authority to make exceptions, and I understand there is an intention to make an exception for use of title in regulated settings such as schools and hospitals, where administration is accountable and there is assurance the public will not be misled.

Motion negated.

Section 30 agreed to.

L'article 30 est adopté.

Section 31 agreed to.

L'article 31 est adopté.

The Chair: Mr Beer moves that the bill be amended by adding, after the heading "Miscellaneous," the following section:

"31.1(1) The council of a band prescribed by the regulations may authorize persons to provide, on the band's reserve, health care services to members of the band.

"(2) This act does not apply with respect to the provision of health care services provided under the authorization of the council of a band prescribed by the regulations.

"(3) In this section, "band," "council of a band," "members of the band," and "reserve" have the same meaning as those terms have, with necessary modifications, in the Indian Act (Canada)."

The Chair: I have a request from Mr Wessenger to make a comment.

Mr Wessenger: Mr Beer, I am wondering if you would consider standing this section down on the basis that we are in a consultation process right now with the native community and it would seem more appropriate to wait until that consultation process is finished. In fact, we are going to stand down, I understand, this whole Bill 43 until that consultation process is finished, and that we deal with your amendment at that time. Would that be agreeable?

Mr Beer: I have no problem about standing this down. I think if there is discussion, that makes every sense. Did I hear you correctly, though? You are saying we are going to stand down the whole of Bill 43?

Mr Wessenger: The completion of the bill.

Mr Beer: We have agreed that we are going to hold Bill 43 open until we have completed all of the bills. Is it still your intention that at the end of that time we would then come back?

Mr Wessenger: That is right, yes.

Mr Beer: Okay, I just wanted to be clear.

The Chair: For the record, let me be clear with what I have heard and make sure all members of committee are satisfied that this is the process. We have a request to stand down proposed section 31.1 until the conclusion of Bill 43. Further, we have a request from Mr Wessenger that Bill 43 be dealt with finally after all the bills inclusive of Bill 64 have been dealt with, so at the end of Bill 64 we will deal once again, finally, with Bill 43 and section 31.1 at that time. That is my understanding.

1610

Mr Wessenger: That is my request, yes.

The Chair: Any discussion? All in favour? Any opposed? Section 31.1 has been stood down until we deal with Bill 43 at the completion of all other bills in the package, and that would be Bill 64.

Section/article 32:

The Chair: Mr Wessenger moves that subsection 32(1) of the bill be amended by inserting after "employed" in the first line "retained" and by striking out "council" in the sixth line and substituting "college."

Mr Wessenger: The purpose of this amendment is to cover the fact that certain individuals are retained rather than employed or appointed, such as a court reporter, interpreter, expert and private investigator. The substitution of "college" for "council" is a housekeeping amendment.

Motion agreed to.

The Chair: Mr Wessenger moves that clause 32(1)(d) of the bill be struck out and the following substituted:

"(d) as may be required for the administration of the Health Insurance Act, Independent Health Facilities Act, 1989 or the Prescription Drug Cost Regulation Act, 1986."

Mr Wessenger: The purpose of the amendment is to permit the flow of information from college officials in order to administer and enforce the named acts. This is necessary because the colleges perform part of the enforcement of the acts.

Motion agreed to.

The Chair: Mr Wessenger moves that subsection 32(3) of the bill be amended by inserting after "report" in the third line "document or thing."

Mr Wessenger: The purpose is to ensure that all documents and objects, ie, the complaints investigation records, are protected. These could be physical objects rather than just reports.

Motion agreed to.

Section 32, as amended, agreed to.

L'article 32, modifié, est adopté.

Sections 33 to 35, inclusive, agreed to.

Les articles 33 à 35, inclusivement, sont adoptés.

Section/article 36:

Mr Beer: Madam Chair, in view of the fact that we have stood down section 26 and that this relates to 26, I ask that this be stood down and we will bring it back next time.

The Chair: I have a motion that section 36 be stood down and dealt with immediately following section 26 in chronological order. There is another motion in between there that would come right after that. Agreed? Section 36 has been stood down and it will be dealt with following the determination on section 26.

Section 37 agreed to.

L'article 37 est adopté.

Section/article 38:

The Chair: Mr Wessenger moves that section 38 of the bill be amended by adding the following subsection:

"(3) Subsection (2) does not apply with respect to a corporation that operates a public hospital within the meaning of the Public Hospitals Act or to a corporation to which part III of the Corporations Act applies."

Mr Wessenger: This amendment excepts members of boards of public hospitals and non-profit corporations from personal liability if they approved, permitted or acquiesced in the hospital or corporation employing a person who unlawfully performs a controlled act.

Motion agreed to.

Section 38, as amended, agreed to.

L'article 38, modifié, est adopté.

Section/article 39:

The Chair: Mr Beer moves that clause 39(1)(b) of the bill be amended by adding at the end "or 28.1(1)."

Mr J. Wilson: Perhaps Mr Beer would provide a reason for the amendment.

The Chair: Section 28.1 was carried.

Mr Beer: Section 28.1 was carried, the new amendment we made was carried—just to cover that off here because it is appropriate.

The Chair: All in favour? Any opposed?

Motion agreed to.

Mr Beer: We have an amendment to clause 39(1)(e) and I would have that stood down pending the discussion of the whole new addition.

The Chair: Mr Beer moves that the amendment to clause 39(1)(e) be stood down until such time as we have dealt with the new proposed section 31.1.

Mr Beer: I think this refers to a band, and it was section 31.1.

The Chair: Any discussion? Motion to stand down. All in favour? Carried. We will stand down clause 39(1)(e) to be dealt with at the same time as the determination on the motion which dealt with this matter previously.

Motion agreed to.

The Chair: At this point, then, we will stand down section 39 in its entirety. All in favour? Carried.

Sections 40 to 42, inclusive, agreed to.

Les articles 40 à 42, inclusivement, sont adoptés.

Section/article 43:

The Chair: Mr Wessenger moves that paragraph 1 of subsection 43(1) of the bill be amended by inserting after "(r)" in the fourth line: "subsection 113(2), section 114, clauses 119(1)(d) and (j) and clause."

Mr Wessenger: It is really to correct supposedly an inadvertent omission. It should have been there.

Motion agreed to.

The Chair: Mr Wessenger moves that section 43 of the bill be amended by adding the following subsection:

"(14.1) Subsection 142(3) of the act is repealed and the following substituted:

"(3) Every manager of a pharmacy shall publicly display his or her licence in the pharmacy."

Mr Wessenger: This replaces the provision requiring a licence of every pharmacist employed in the pharmacy to be displayed. It was felt it was not practical because of the part-time pharmacists coming in and out. It is just the manager's that has to be displayed, and it has been requested by the Ontario College of Pharmacists.

Motion agreed to.

Section 43, as amended, agreed to.

L'article 43, modifié, est adopté.

1620

Section/article 44:

The Chair: Mr Wessenger moves that section 44 of the bill be struck out and the following substituted:

"44. The Ontario Dietetic Association Act, 1958 is repealed."

Mr Wessenger: This is amended because the association has requested the repeal of this private act. The association prefers to re-incorporate under the Corporations Act.

Mr Beer: I take it you say that the Dietetics Act, 1991 is proposed. Is there going to be then a time frame between which there is no association act? Is there anything that could go awry because one may come after the other?

Mr Wessenger: I understand the association is well aware it has to incorporate its new corporation before this act is proclaimed.

Motion agreed to.

Section 44, as amended, agreed to.

L'article 44, modifié, est adopté.

Sections 45 and 46 agreed to.

Les article 45 et 46 sont adoptés.

Table/tableau:

The Chair: Mr Wessenger moves that the French version of the table to the bill be amended (a) by striking out "techniciens" in the second line of the entry in column 2 of item 2 and substituting "technologues," (b) by striking out "denturologues" in the second line of the entry in column 2 of item 3 and substituting "denturologistes," and (c) by striking out "techniciens" in the second line of the entry in column 2 of item 16 and substituting "technologues."

Mr Wessenger: The purpose of this amendment is that it accommodates each profession's preference for a particular

French title. It is the profession's own preference of what language be used and we are merely accommodating that.

Motion agreed to.

Table, as amended, agreed to.

Le tableau, modifié, est adopté.

Schedule/annexe 1:

The Chair: Mr Wessenger moves that the French version of schedule 1 of the bill be amended (a) by striking out "audiologues" in the first item and substituting "audiologistes," (b) by striking out "denturologues" in the fourth item and substituting "denturologistes," (c) by striking out "techniciens" in the third last item and substituting "technologues," and (d) by striking out "techniciens" in the last two items and substituting, in each item, "technologues."

Mr Wessenger: The reason is the same as for the previous amendment.

Motion agreed to.

Schedule 1, as amended, agreed to.

L'annexe 1, modifiée, est adoptée.

Schedule/annexe 2:

Section/article 1:

The Chair: Mr Wessenger moves that subsection 1(1) of schedule 2 to the bill be amended by adding the following definition:

"'Council' means the council of the college; ('conseil')."

Mr Wessenger: Just a housekeeping amendment again.

Motion agreed to.

The Chair: Mr Wessenger moves that subsection 1(1) of schedule 2 of the bill be amended by adding the following definition:

"'patient relations program' means a program to enhance relations between members and patients."

Mr Wessenger: This is a definition section related to the new patient relations committee and program.

Mr J. Wilson: Perhaps we could stand this down a little. It is just a definition at this point. We should have some discussion about the new patient relations program and what the government's intention in this whole area is, because we have only had brief introductory comments last week from the parliamentary assistant and I think we should have a further discussion on it.

The Chair: So are you requesting that all of schedule 2 be stood down until section 26 has been dealt with, or are you asking that just this amendment to schedule 2 be stood down?

Mr J. Wilson: This amendment at the moment.

The Chair: Okay. We have a request to stand this amendment down. Any discussion? All in favour? Any opposed? We shall stand down this amendment to schedule 2, subsection 1(1) until we deal with section 26 next Monday.

Mr Wessenger: Madam Chair, it is 81(1).

The Chair: Just to be clear, schedule 2, subsection 1(1) is stood down until there is discussion of 81(1) on the schedule.

Section 2 agreed to.
L'article 2 est adopté.

Section/article 3:

The Chair: Mr Wessenger moves that subsection 3(1) of schedule 2 of the bill be amended by adding the following paragraph:

"5.1. To develop, establish and maintain programs to assist individuals to exercise their rights under this code and the Regulated Health Professions Act, 1991."

Mr Wessenger: The purpose of this amendment is to ensure that colleges have responsibility to develop programs so individuals can exercise their rights under the legislation.

Motion agreed to.

Section 3, as amended, agreed to.
L'article 3, modifié, est adopté.

Section 4 agreed to.
L'article 4 est adopté.

Section/article 5:

The Chair: Mr Wessenger moves that section 5 of schedule 2 to the bill be struck out and the following substituted:

"5(1) No term of a council member who is elected shall exceed three years.

"(2) A person may be a council member for more than one term, but no person who is elected may be a council member for more than nine consecutive years.

"5.1 A majority of the members of the council constitute a quorum."

Mr Wessenger: This is an amended version of an amendment previously circulated. The earlier version limited terms of both elected and appointed public members to six years. In responding to submissions from the colleges, the maximum length has been extended to nine years and the limit applies to elected members only. Government policy traditionally limits public members' terms to six years. It is felt there is a limit necessary to ensure that fresh blood is brought on to the councils. Also, nine years, we feel, permits progression through committee and offices and lessens the member's reliance on college bureaucrats.

Motion agreed to.

1630

The Chair: Mr Wilson moves that section 5 of schedule 2 of the bill be amended by adding the following subsection:

"(2.1) A council member may not be appointed by the Lieutenant Governor in Council if the appointment would reduce the percentage of elected members of the council to less than 60% of the total number of members of the council."

Mr J. Wilson: The purpose of this amendment is that the government has announced its intention to increase the number of lay representatives to just under half of the composition of the college councils. We do not believe that a council made up of almost equal numbers of health care professionals and laypeople is a self-regulated body. We believe the government's intention to have just under 50% lay members would erode self-regulation and the principle

of peer review. Therefore, the amendment supports the contention that the ratio should be 60-40, 60% members of the college and 40% lay members.

Mr Wessenger: I would like to speak in opposition to the amendment. In most cases we have negotiated with the college's specific representation. The principle that has been used is just under half, not a fixed percentage. It is contrary to government policy to require that 60% of the representatives be members of the college.

Mr Beer: I have a question to the parliamentary assistant. Could you elaborate on these agreements with the colleges? I take it you mean by this that some of the councils will be perhaps 42% or 44%, but that they will all vary because the numbers are different and those have been negotiated with each council directly. Is that correct?

Mr Wessenger: That is correct. The percentages will vary with each council because the representation is negotiated with the council and the government, so there are variations. In some cases it might be 49%. Also, the arithmetic does not work out exactly in percentage terms, so it will be a varying percentage.

Motion negated.

Section 5, as amended, agreed to.
L'article 5, modifié, est adopté.

Sections 6 and 8, inclusive, agreed to.

Les articles 6 à 8, inclusivement, sont adoptés.

Section/article 9:

The Chair: Mr Wessenger moves that section 9 of schedule 2 of the bill be amended by adding the following paragraph:

"7. Patient relations committee."

Mr Wessenger: I might explain that this is the patient relations committee mentioned in my opening remarks. This makes the patient relations committee a mandatory committee of each college.

The Chair: Do you want to stand that down, Mr Wilson?

Mr J. Wilson: Yes, Madam Chair.

The Chair: We have a request to stand it down until we deal with all of the related sections. Any comment? All in favour? Any opposed? We will stand down section 9 of schedule 2 to the appropriate time.

Mr Beer: I believe I can move—

The Chair: Just a second. Do you want to just put it on the record and then we will stand it down?

Mr Beer: Yes. Is that the way we might proceed with subsections 9(2) and (3) of schedule 2?

The Chair: Yes.

Mr Beer moves that section 9 of schedule 2 of the bill be amended by adding the following subsections:

"(2) The council shall appoint the members of the committees.

"(3) The composition of the committees shall be in accordance with the regulations."

Mr Wessenger: Mr Beer, I think we can proceed with this, because it does not relate to the patient relations committee.

The Chair: Did you want to comment on this?

Mr Beer: I think it is fairly self-explanatory, just to make clear the council's role, that it will be appointing the members.

Mr Wessenger: I would like to support this amendment because I think it provides a more flexible way of determining committee composition.

Motion agreed to.

The Chair: So we are going to stand down section 9 to be dealt with, but we have amended part of it already.

Sections 10 to 12, inclusive, agreed to.

Les articles 10 à 12, inclusivement, sont adoptés.

Section/article 13:

Mr Wessenger: I have an amendment to section 13.

The Chair: Mr Wessenger moves that section 13 of schedule 2 of the bill be struck out and the following substituted:

"(13(1) A person whose certificate of registration is revoked or who resigns as a member continues to be subject to the jurisdiction of the college for professional misconduct referable to the time when the person was a member.

"(2) A person whose certificate of registration is suspended continues to be subject to the jurisdiction of the college for incapacity and for professional misconduct or incompetence referable to the time when the person was a member or to the period of the suspension."

Mr Wessenger: The purpose of this is to cover a situation that should have been covered in the original version.

Motion agreed to.

Section 13, as amended, agreed to.

L'article 13, modifié, est adopté.

Sections 14 to 17, inclusive, agreed to.

Les articles 14 à 17, inclusivement, sont adoptés.

1640

Section/article 18:

The Chair: Mr Wessenger moves that subsection 18(1) of schedule 2 be struck out and the following substituted:

"(18(1) A member may apply to the registration committee for an order directing the registrar to remove or modify any term, condition or limitation imposed on the member's certificate of registration as a result of a registration proceeding.

"(1.1) The right to apply under subsection (1) is subject to any limitation in the order imposing the term, condition or limitation or to which the member consented and to any limitation made under subsection (6) in the disposition of a previous application under this section."

Mr Wessenger: This is merely an amendment to clarify the earlier version.

Motion agreed to.

Section 18, as amended, agreed to.

L'article 18, modifié, est adopté.

Section 19 agreed to.

L'article 19 est adopté.

Section/article 20:

The Chair: Mr Wessenger moves that subsection 20(3) of schedule 2 be amended by striking out "forthwith" in the third line and substituting "within 15 days after receiving the notice."

Mr Wessenger: This amendment requires the college to send a record of complaint investigation to the health professions board within 15 days of notice of complaint instead of forthwith. This was recommended by the Health Discipline Board council, because it gives it a more definite time frame rather than just the word "forthwith," which in effect almost means immediately.

Motion agreed to.

The Chair: Mr Wessenger moves that subsection 20(4) of schedule 2 be amended by renumbering clause (a) as clause (a.1) and adding the following clause:

"(a) the applicant has given the registrar notice that the applicant will not be requiring a review or hearing."

Mr Wessenger: This is just a procedural refinement.

Motion agreed to.

Section 20, as amended, agreed to.

L'article 20, modifié, est adopté.

Section/article 21:

The Chair: Mr Wessenger moves that subsection 21(8) of schedule 2 be struck out and the following substituted:

"(8) The board, in making an order under subsection (6), shall not require the registration committee to direct the registrar to issue a certificate of registration to an applicant who does not meet a registration requirement that is prescribed as a non-exemptible requirement."

Mr Wessenger: It is to correct a technical error in the original provision.

Motion agreed to.

Section 21, as amended, agreed to.

L'article 21, modifié, est adopté.

Section/article 22:

The Chair: Mr Wessenger moves that clause 22(2)(f) of schedule 2 be struck out and the following substituted:

"(f) information that a panel of the registration, discipline or fitness to practise committee specifies shall be included; and."

Mr Wessenger: This, again, is a housekeeping amendment clarifying that in addition to the registrar being authorized to enter information on a register, the panel of the registration, discipline or fitness to practise committees can specify what information is to be included on that entry.

Motion agreed to.

The Chair: Mr Wessenger moves that the French version of subsection 22(3) of schedule 2 to the bill be amended by inserting after "bureau" in the second line "normales."

Motion agreed to.

The Chair: Mr Wessenger moves that subsection 22(3) of schedule 2 to the bill be amended by adding the following paragraph:

"1.1 Information described in clause (2)(d) relating to a suspension that is in effect."

Mr Wessenger: This amendment is necessary because the public interest warrants public access to information on anyone currently suspended.

Motion agreed to.

Mr J. Wilson: Madam Chair, were those last comments actually directed to that amendment?

The Chair: No. It was actually grammatical clarity, I think.

Mr J. Wilson: I think so. I thought maybe I was in a different committee for a minute.

The Chair: At least everyone is paying attention.

Mr Wessenger moves that subparagraph 22(3)2ii of schedule 2 to the bill be amended by striking out "the discipline or fitness to practise committee" in the last two lines and substituting "a panel of the discipline or fitness to practise committee."

Mr Wessenger: This allows a panel rather than the whole committee. It is a housekeeping amendment.

Motion agreed to.

The Chair: Mr Wessenger moves that section 22 of schedule 2 of the bill be amended by adding the following subsections:

"(3.1) In disposing of a matter, a panel of the registration, discipline or fitness to practise committee may, for the purposes of clause (2)(f), specify information to be included in the register.

"(3.2) In disposing of a matter, a panel of the discipline or fitness to practise committee may, for the purposes of subparagraph (3)2ii, direct that the results of the proceeding be included in the register."

Mr J. Wilson: Obviously the amendment helps to clarify what information may be contained in the register. I would just like to ask the parliamentary assistant, does it serve to help those nurses, for instance, who were very much worried about their home addresses and that sort of thing being released?

Mr Wessenger: No, it really does not speak to that matter. This really relates to where there has been a proceeding and a finding. The panel can specify what specifically its finding was and how it should be entered in the register to make sure it is accurate.

Motion agreed to.

Section 22, as amended, agreed to.

L'article 22, modifié, est adopté.

Section/article 23:

The Chair: Mr Wessenger moves that section 23 of schedule 2 of the bill be amended by striking out "revoke" in the first and last lines and substituting "suspend."

Mr Wessenger: This is a housekeeping amendment substituting the word "suspend" for "revoke."

Motion agreed to.

Section 23, as amended, agreed to.

L'article 23, modifié, est adopté.

Section/article 24:

The Chair: Mr Wessenger.

Mr Wessenger: I move that section 24 of schedule 2 of the bill be amended by adding the following subsection—

The Chair: That is a PC motion.

Mr Wessenger: Oh, excuse me.

The Chair: I take back what I said about paying attention. The Chair apologizes. I called on Mr Wessenger. It was not a test; it was an oversight.

Mr J. Wilson: I am certainly grateful for the indication of support from the parliamentary assistant. If he likes, he can read our motion into the record.

The Chair: We were on a roll there, but I do apologize.

Mr J. Wilson: He is doing well. I sure hope he will vote for it.

The Chair: I would not count on that, Mr Wilson.

Mr Wilson moves that section 24 of schedule 2 of the bill be amended by adding the following subsection:

"(4.1) Despite subsection (4), a panel shall be selected if the complainant has a disability and the complaint is recorded on a tape, file, disc or other medium."

1650

Mr Owens: Just a quick question to the mover of the amendment. Would you agree, as a friendly amendment, to deal with folks who also have literacy problems, as people with literacy problems are unable to read or write as well?

Mr J. Wilson: I think this attempts to deal with some of those problems. Currently the way the subsection reads is that the complaint must be in writing before a complaints panel will be constituted. This allows other options of communicating.

Mr Owens: But I think you would have to agree that when one talks about a disability, one does not usually include literacy problems in that definition.

Mr J. Wilson: I would think a person with literacy problems would be able now—and you should agree with the amendment—to put forward a complaint on tape or film or disc or another medium, and I certainly think your concerns are encompassed in the amendment.

Mr Owens: I think what I am suggesting, Jim, is that—

The Chair: I think he said no to your request.

Mr J. Wilson: No, I did not say no.

The Chair: If you wish to move an amendment to the amendment, you must do so in writing. You can do that, but from the debate and the discussion, he has not agreed to amend his amendment at this time.

Mr J. Wilson: I do, but I do not understand your amendment. Perhaps you could give me some wording on it. I see this amendment as encompassing that already, without specifying each and every possible disability.

Mr Beer: I think this does cover the way in which a complaint can be recorded. I am asking a question of the parliamentary assistant that follows on from what Mr Owens was just asking in terms of the definition of disabilities. This would capture anyone who would need to use tape, film, disc or other media and that would be useful to have in the legislation.

Mr Wessenger: I would like to ask that this be stood down so we can have further time to consider it and come up with appropriate language. I think it is a good concept that has been put forward here, but I think we would like to have it stood down to see what we can come up with in the appropriate language.

Mr J. Wilson: This is not a controversial amendment, but sure, if you would like to.

The Chair: All in favour? Any opposed?

Agreed to.

The Chair: We will stand that down until the appropriate time.

Section/article 25:

The Chair: Mr Wessenger moves that paragraph 25(2)3 of schedule 2 to the bill be amended by inserting after "panel" in the second line "or another panel of the complaints committee."

Mr Wessenger: This is required because in practice it cannot be guaranteed that the panel that considers the submissions will be the same panel that cautions the member.

Motion agreed to.

Section 25, as amended, agreed to.

L'article 25, modifié, est adopté.

Section 26 agreed to.

L'article 26 est adopté.

Section/article 27:

Mr J. Wilson: We are withdrawing our amendment regarding subsection 27(1) of schedule 2.

The Chair: That is withdrawn, thank you.

Section 27 agreed to.

L'article 27 est adopté.

Section/article 28:

The Chair: Mr Wessenger moves that the French version of subsection 28(2) of schedule 2 of the bill be amended (a) by striking out "avait pour objet" in the fourth line; (b) by striking out "de renvoyer" in the first line of clause (a) and substituting "renvoyait"; and (c) by striking out "d'adresser" in the first line of clause (b) and substituting "adressait."

Motion agreed to.

Mr J. Wilson: I point out at this time that we are withdrawing our proposed amendment to subsection 28(4).

Section 28, as amended, agreed to.

L'article 28, modifié, est adopté.

Sections 29 and 30 agreed to.

Les articles 29 et 30 sont adoptés.

Section/article 31:

The Chair: Mr Wessenger moves that subsection 31(2) of schedule 2 of the bill be amended by striking out "and to the complaints committee" in the second and third lines.

Mr Wessenger: This amendment is recommended because requiring the board to disclose to the complaints committee everything given to it by the registrar is redundant where the complaints committee has investigated the complaint.

Motion agreed to.

Section 31, as amended, agreed to.

L'article 31, modifié, est adopté.

Section/article 32:

The Chair: Mr Wessenger moves that clause 32(2)(b) of schedule 2 of the bill be struck out and the following substituted:

"(a.1) may require the college to send a representative;

"(b) may question the parties and the representative of the college."

Mr Wessenger: This amendment authorizes the Health Disciplines Board to require college representatives to attend for questioning at complaint review. It was suggested by the board counsel because sometimes no college representatives attend, to the detriment of the review.

Motion agreed to.

Section 32, as amended, agreed to.

L'article 32, modifié, est adopté.

Section/article 33:

The Chair: Mr Wessenger moves that paragraph 2 of section 33 of schedule 2 of the bill be struck out.

Mr Wessenger: This is a housekeeping amendment.

Motion agreed to.

Section 33, as amended, agreed to.

L'article 33, modifié, est adopté.

Sections 34 and 35 agreed to.

Les articles 34 et 35 sont modifiés.

Section/article 36:

The Chair: Mr Wessenger moves that clause 36(1)(a) of schedule 2 to the bill be struck out and the following substituted:

"(a) an allegation is referred to the discipline committee."

Mr Wessenger: Again, it is just a housekeeping amendment.

Motion agreed to.

The Chair: Mr Wessenger moves that section 36 of schedule 2 to the bill be amended by adding the following subsection:

"(3.1) In a matter in which an order under subsection (1) was made, an order of a panel of the discipline committee directing the registrar to revoke, suspend or impose conditions on a member's certificate takes effect immediately despite any appeal."

Mr Wessenger: The purpose of this is because the college has power to suspend registration before a discipline hearing in extraordinary cases, and usually an order of the discipline committee is stayed pending appeal. In those extraordinary cases, an order should not be stayed,

Motion agreed to.

Section 36, as amended, agreed to.

L'article 36, modifié, est adopté.

1700

Section/article 37:

The Chair: Mr Wessenger moves that subsection 37(3) of schedule 2 of the bill be amended by striking out "one" in the first line and substituting "at least one."

Mr Wessenger: This amendment is to require at least one member of a discipline panel to be both a member of the college and a member of the council.

Motion agreed to.

The Chair: Mr J. Wilson moves that subsection 37(5) of schedule 2 of the bill be struck out and the following substituted:

"(5) Three members of a panel, at least one of whom must be a member who was appointed to the council by the Lieutenant Governor in Council, constitute a quorum."

Mr J. Wilson: The intention here is to ensure that a public member is present throughout the discipline hearing process and the decision-making process, and not just for a hearing to commence.

Mr Wessenger: I support this amendment because the discipline committee must have between three and five members, of whom at least two must be public members. I think it is important to ensure that there will be a consistency of one public member through the hearing.

Motion agreed to.

The Chair: Shall section 37, as amended, carry? All in favour? Any opposed? Carried.

Section 37, as amended, agreed to.

L'article 37, modifié, est adopté.

Mr Wessenger: Could we hold for a minute?

The Chair: We have a request from Mr Wessenger to just hold the proceedings. You may want to recess for five minutes. We will stand down for five minutes and recess.

The committee recessed at 1702.

1709

The Chair: The standing committee on social development is now in session.

Mr Beer: It was drawn to my attention that one of the clauses I asked to be stood down need not be stood down, if I might just return to it. It is subsection 36(1).

The Chair: A section of the bill, not in the schedule.

Mr Beer: Not in the schedule.

The Chair: We have a request to go back to the bill to subsection 36(1).

Mr Beer moves that subsection 36(1) be amended by inserting after "26(1)" in the second line "or 28.1(1)."

Mr Beer: I do not know how anybody following this on television would understand. We are talking gobbledegook. I stood this down because of the reference to subsection 26(1), but in fact it is subsection 36(1) and any discussion or changes we make to section 26 later on can then be changed. All we are doing here is adding "or 28.1(1)" which we had in fact approved. I would ask that we now approve this amendment.

Mr Wessenger: Yes, I agree with that. It is a consequential amendment to the previous amendment that passed.

The Chair: I am going to call the vote on the amendment to subsection 36(1) of the bill. All in favour of the amendment? Any opposed?

Motion agreed to.

The Chair: We still have some parts of section 36 that have been stood down; is that correct?

Clerk of the Committee: Yes, subsection 36(2).

The Chair: So there are still some parts of section 36 that have been stood down for discussion at another time.

Schedule/annexe 2:

Section/article 38:

The Chair: Mr Wilson, we are now back on schedule 2. You have an amendment that I believe you want to place at this time to section 38.

Mr Wilson moves that subsection 38(1) of schedule 2 of the bill be struck out.

Mr J. Wilson: The purpose is to make that consistent with my previous amendment.

Mr Wessenger: Yes, I support that. It is consistent and it should be passed.

The Chair: All in favour? Any opposed?

Motion agreed to.

Section 38, as amended, agreed to.

L'article 38, modifié, est adopté.

Section/article 39:

The Chair: Mr Wilson moves that section 39 of schedule 2 of the bill be amended by adding the following subsections:

"(2) A panel may at any time permit a notice of hearing of allegations of sexual abuse of a patient by a member to be amended if it is of the opinion that it is just and equitable to do so, and the panel may make any order it considers necessary to prevent prejudice to the member.

"(3) In subsection (2), 'sexual abuse' means conduct that is sexual including, without limiting the generality of the foregoing, improper touching or kissing."

I have a motion from Mr Wilson that this matter be stood down and dealt with at the appropriate time.

Mr Beer: With the committee's indulgence, I would agree with that. I just wanted to be clear, as I am going to have to leave shortly. There are several others that I think relate to this. Is there agreement that all of the ones that relate to sexual abuse and the patients' committee would then be dealt with together?

Mr J. Wilson: Agreed.

The Chair: The motion to stand down section 39 will be amended to include the standing down of all amendments to the schedule which relate to the issue of sexual abuse, sexual assault, that they also be stood down and dealt with at the appropriate time.

Motion agreed to.

Mr J. Wilson: On a point of information for the committee, you should not spend time this evening considering our amendment, which was coming along next, to schedule 2, section 40, the PC motion. We are withdrawing that.

Sections 40 to 43, inclusive, agreed to.

Les articles 40 à 43, inclusivement, sont adoptés.

Section/article 44:

The Chair: Mr Wessenger moves that subsection 44(2) of schedule 2 be amended by striking out the first three lines and substituting:

"The panel may make an order that the public be excluded from a hearing or any part of it if the panel is satisfied that."

Mr Wessenger: This increases the flexibility of orders that have been made to exclude the public from the hearings.

The Chair: On the amendment, Mr Wilson.

Mr J. Wilson: Excuse me, Madam Chair, is that section 44.1?

Mr Wessenger: No, it is subsection 44(2).

Mr J. Wilson: I think the parliamentary assistant skipped one.

The Chair: We are dealing first with 44(2). In your book, Mr Wilson, they are just out of order. Mr Wessenger is correct in moving the amendment to subsection 44(2) first.

Motion agreed to.

Section 44, as amended, agreed to.

L'article 44, modifié, est adopté.

The Chair: Mr Wessenger moves that schedule 2 to the bill be amended by adding the following section:

"44.1 If a panel makes an order under subsection 44(2), wholly or partly because of the desirability of avoiding disclosure of matters in the interest of a person affected, the panel may allow the person and his or her personal representative to attend the hearing."

Mr J. Wilson: Perhaps we could have a further explanation from the parliamentary assistant.

Mr Wessenger: The discipline committee may exclude the public from hearings to protect an individual's interests, and this amendment ensures that the individual and representative may remain despite the exclusion order. A general order excluding the public would also exclude the complainant, so this allows the complainant to remain.

Mr J. Wilson: I appreciate the comments.

Motion agreed to.

Section 45 agreed to.

L'article 45 est adopté.

Section/article 46:

The Chair: Mr J. Wilson moves that subsection 46(1) of schedule 2 be amended by adding the following clause:

"(b.1) copies of the transcript of the hearing are available to the complainant on the complainant's request."

Mr J. Wilson: The intent here is that copies of the transcript of a hearing are to be made available to the patient where the patient is not a party.

Mr Wessenger: Mr Wilson, could I ask you a question with respect to this amendment, and that is, who would pay the cost of the transcript?

Mr J. Wilson: It is a very good question. We feel, none the less, that it is important that the patient be allowed to have a copy, and perhaps cost is something we should discuss right now.

Mr Wessenger: Yes, I think it is something we should discuss, because again—

Mr J. Wilson: It can be very costly. I understand that, yes.

Mr Wessenger: If a transcript has already been prepared, then there is a fairly minimal cost to providing a copy of the transcript to the complainant. If, however, there has been a hearing and no transcript has been prepared, the cost of preparing a transcript could be very expensive, \$300 or something.

Mr J. Wilson: As is the case with our court systems, I certainly would not be opposed to the patients having to pay for the transcripts themselves.

Mr Wessenger: If you would like to make that amendment—

Mr J. Wilson: I would make that amendment.

The Chair: You have to make it in writing, Mr Wilson. Shall we stand it down for a moment?

Mr J. Wilson: Yes, fine. We move to stand it down.

Motion agreed to.

Sections 47 and 48 agreed to.

Les articles 47 et 48 sont adoptés.

1720

Section/article 49:

The Chair: Mr Wessenger moves that clause 49(1)(a) of schedule 2 of the bill be amended by striking out "convicted" in the first line and substituting "found guilty."

Mr Wessenger: The purpose of this amendment is that we want to include the situation where a member has been found guilty of an offence but has been granted a conditional or absolute discharge by the court.

Motion agreed to.

Section 49, as amended, agreed to.

L'article 49, modifié, est adopté.

Sections 50 to 63, inclusive, agreed to.

Les articles 50 à 63, inclusivement, sont adoptés.

Section/article 64:

The Chair: Mr Wessenger moves that subsections 64(1) and (2) of schedule 2 to the bill be struck out and the following substituted:

"64(1) A report prepared and signed by a health professional containing his or her findings and the facts upon which they are based is admissible as evidence at a hearing without proof of its making or of the health professional's signature if the party introducing the report gives the other parties a copy of the report at least 10 days before the hearing.

"(2) A health professional may not give evidence in his or her professional capacity at the hearing unless a report, prepared and signed by the health professional containing his or her findings and the facts upon which they are based, is introduced as evidence."

Mr Wessenger: The reason for this amendment is to make the rules similar to the courts with respect to the providing of medical reports as evidence.

Motion agreed to.

Section 64, as amended, agreed to.

L'article 64, modifié, est adopté.

Sections 65 to 67, inclusive, agreed to.

Les articles 65 à 67, inclusivement, sont adoptés.

Section/article 68:

The Chair: Mr Wessenger moves that subsection 68(3) of the bill be struck out and the following substituted:

"(3) In an appeal under subsection (1), the court has all the powers of the panel that dealt with the matter and, in an appeal from the board, the court also has all the powers of the board."

Mr Wessenger: This is necessary to ensure that the court can substitute its decision for that of the board, if that is appropriate.

Section 68, as amended, agreed to.

L'article 68, modifié, est adopté.

Sections 69 to 79, inclusive, agreed to.

Les articles 69 à 79, inclusivement, sont adoptés.

Section/article 80:

The Chair: Mr Wessenger moves that subsections 80(2), (3) and (4) of schedule 2 to the bill be struck out and the following substituted:

"(2) Every person who controls premises where a member practises, other than a private dwelling, shall allow an assessor to enter and inspect the premises.

"(3) Every person who controls records relating to a member's care of patients shall allow an assessor to inspect the records.

"(4) Subsection (3) does not require a patient or his or her representative to allow an assessor to inspect records relating to the patient's care."

Mr Wessenger: This amendment gives the college quality assurance, assessors wider access to practice premises and patient records when they are doing an investigation.

Motion agreed to.

Section 80, as amended, agreed to.

L'article 80, modifié, est adopté.

Section 81 agreed to.

L'article 81 est adopté.

The Chair: Mr Wessenger moves that schedule 2 of the bill be amended by adding, before the heading "Miscellaneous," the following sections:

"81.1(1) The council shall make regulations under paragraph 22.1 of subsection 91(1) prescribing a patient relations program.

"(2) The patient relations program must include measures for the prevention of professional misconduct of a sexual nature.

"81.2 The patient relations committee shall advise the council with respect to the patient relations program.

"81.3(1) There shall be a patient relations monitoring board to monitor the patient relations program.

"(2) The board shall be composed of representatives of,

"(a) the public;

"(b) the members; and

"(c) the unions and professional associations that represent members.

"(3) The number of representatives shall be determined by the council.

"(4) The number of representatives of the public shall be at least equal to the total number of representatives of

the members and the unions and professional associations that represent members.

"(5) The minister shall appoint, as representatives of the public, persons who are not,

"(a) members of the college or any other college as defined in the Regulated Health Professions Act, 1991; or

"(b) members of the council or any other council as defined in the Regulated Health Professions Act, 1991.

"(6) The council shall appoint the representatives of the members.

"(7) The council shall determine the unions and professional associations that represent members and they shall appoint their representatives.

"81.4 The Patient Relations Monitoring Board shall make an annual report to the college."

1730

Mr Wessenger: I would ask that this be stood down to be considered with the other items.

The Chair: All right. You could go back at this point if you wish, Mr Wessenger, and deal with schedule 2, subsection 1(1), the patient relations program, and schedule 2, section 9, which deals with the patient relations committee, or do you want to stand the whole thing down?

Mr Wessenger: I think I would prefer to stand down. I think we would rather deal with it tomorrow.

The Chair: There is a motion to stand down the amendment, new sections to schedule 2, 81.1 to 81.4.

Motion agreed to.

The Chair: Mr J. Wilson moves that schedule 2 of the bill be amended by adding, before the heading "Miscellaneous," the following sections:

"81.1(1) The college shall establish a fund to be known in English as the survivors compensation fund and in French as the fonds d'indemnisation des victimes.

"(2) The survivors compensation fund shall be administered by the survivors compensation fund committee.

"81.2(1) The college shall have a committee called the survivors compensation fund committee.

"(2) The committee shall be composed of three persons, at least two of whom must be members of the council appointed to the council by the Lieutenant Governor in Council.

"(3) The chair of the committee shall be selected by the committee from among its members who are members of the council appointed to the council by the Lieutenant Governor in Council.

"81.3(1) The fund shall be used for the purpose of assisting patients and former patients who have been victims of professional misconduct of a sexual nature by members or former members.

"(2) The committee may make payments from the fund for treatment or counselling related to the misconduct and for associated expenses.

"81.4(1) A member or former member who is found to have committed an act of professional misconduct of a sexual nature with respect to a patient shall pay into the survivors compensation fund any fees received for services rendered to the patient in the period during which the misconduct occurred.

"(2) An amount required to be paid under subsection (1) is a debt that may be recovered by the committee in a civil proceeding."

Mr J. Wilson: As per our previous agreement, this dealing with the matter of sexual abuse, I move, of course, that this amendment be stood down.

The Chair: I have a motion that this amendment be stood down and dealt with at the appropriate time with the other amendments on this issue.

Motion agreed to.

Sections 82 to 84, inclusive, agreed to.

Les articles 82 à 84, inclusivement, sont adoptés.

Section/article 85:

The Chair: Mr Wilson moves that section 85 of schedule 2 to the bill be amended by adding the following subsections:

"(3) This section and the Limitations Act do not apply with respect to an action arising out of a person's sexual abuse of a patient while the person was a member.

"(4) In subsection (3), 'sexual abuse' means conduct that is sexual including, without limiting the generality of the foregoing, improper touching or kissing."

Mr J. Wilson: I also move, Madam Chair, consistent with the previous amendment that I introduced, that this be stood down at this time.

The Chair: There is a motion that the amendment be stood down till the appropriate time.

Motion agreed to.

The Chair: There is a motion to stand down all of section 85.

Motion agreed to.

Section/article 86:

The Chair: Mr Wessenger moves that section 86 of schedule 2 of the bill be amended by adding the following subsection:

"(1.1) If a person intended to terminate the employment of a member or to revoke the member's privileges for reasons of professional misconduct, incompetence or incapacity but the person did not do so because the member resigned or voluntarily relinquished his or her privileges, the person shall file with the registrar within 30 days after the resignation or relinquishment a written report setting out the reasons upon which the person had intended to act."

Mr Wessenger: This amendment is to cover the situations where an employee resigns from his position of employment, such as in a health care facility, for a reason relating to professional misconduct, and requires that the information be reported to the college so it is on record.

Mr J. Wilson: The person who actually is resigning has to file with the registrar within 30 days?

Mr Wessenger: An employer has to file the information.

Mr J. Wilson: So "person" here means employer?

Mr Wessenger: Yes, because if a person intended to terminate the employment, it is the person terminating the employment, not the employee.

Motion agreed to.

Section 86, as amended, agreed to.

L'article 86, modifié, est adopté.

Sections 87 and 88 agreed to.

Les articles 87 et 88 sont adoptés.

Section/article 89:

The Chair: Mr Wessenger moves that subsection 89(1) of schedule 2 to the bill be amended by adding after "section 44" in the second line "or 45."

Mr Wessenger: This amendment clarifies that breach of an order made under section 45 of schedule 2 is an offence.

Motion agreed to.

The Chair: Mr Wessenger moves that subsection 89(3) of schedule 2 to the bill be amended by striking out "80(3), (4)" in the second line and substituting "80(2), (3)."

Mr Wessenger: This is a housekeeping amendment.

Motion agreed to.

Section 89, as amended, agreed to.

L'article 89, modifié, est adopté.

Section 90 agreed to.

L'article 90 est adopté.

Section/article 91:

The Chair: Mr Wessenger moves that paragraph 3 of subsection 91(1) of schedule 2 to the bill be struck out and the following substituted:

"(3) Prescribing conditions disqualifying elected members from sitting on the council and governing the removal of disqualified council members."

Mr Wessenger: This amendment enables a college to impeach a committee member who initially qualified.

Mr J. Wilson: Madam Chair, that replaces a section that also gave the authority for filling vacancies on the council. How is that now done? It is probably covered somewhere else; I just do not know where.

Mr Wessenger: There is a second motion that will clear that up, the next motion, 5 and 5.1.

Mr J. Wilson: Okay, thank you.

Motion agreed to.

1740

The Chair: Mr Wessenger moves that paragraph 5 of subsection 91(1) of schedule 2 to the bill be struck out and the following substituted:

"5. Prescribing conditions disqualifying committee members from sitting on committees and governing the removal of disqualified committee members;

"5.1 Respecting the filling of vacancies on the council or its committees."

Mr Wessenger: This amendment authorizes the council to make regulations governing the creation of a vacancy by disqualification and removal, in addition to the existing regulatory power governing how to fill any vacancy.

Motion agreed to.

The Chair: Mr Cordiano moves that subsection 91(1) of schedule 2 of the bill be amended by adding the following paragraph:

"5.2 Providing for the composition of the committees mentioned in section 9."

Interjection: It is consequential.

Mr Wessenger: Yes, it is consequential. Yes, we do support that amendment.

Motion agreed to.

The Chair: Mr Wessenger moves that subsection 91(1) of schedule 2 of the bill be amended by adding the following paragraph:

"14.1 Governing or prohibiting the delegation by or to members of controlled acts set out in subsection 26(2) of the Regulated Health Professions Act, 1991."

Mr Wessenger: This amendment in the code authorizes college councils to make regulations governing the delegation of controlled acts by or to members of the college.

Mr Hope: It seems we have not dealt with subsection 26(2). Is it appropriate that it be carried at this time?

Mr Wessenger: Yes, I believe it is appropriate, because it is just the procedural code.

Mr J. Wilson: My reading of it is it simply clarifies the authority of the college for something that all committee members agree is within the scope of this act.

The Chair: I think that is an accurate reading of what is proposed.

Motion agreed to.

The Chair: Mr Wessenger moves that subsection 91(1) of schedule 2 of the bill be amended by adding the following paragraph:

"22.1. Prescribing a patient relations program;"

And he further moves that subsection 91(2) of schedule 2 of the bill be amended by inserting after "22" in the first line, "or 22.1."

Mr Wessenger: I think we should stand this down for consideration with the others.

The Chair: There is a motion to stand this amendment down until the appropriate time.

Motion agreed to.

The Chair: Mr Wessenger moves that paragraph 25 of the subsection 91(1) of schedule 2 to the bill be struck out and the following substituted:

"25. Requiring members to give the college their home addresses and prescribed information about the places they practise the profession, the services they provide there and the names, business addresses and telephone numbers of their associates, partners and employees and prescribing the form and manner in which the information shall be given."

Mr Wessenger: This amendment authorizes the council to require members to provide their home addresses and prescribed information about where they practise and the services provided.

Motion agreed to.

The Chair: Mr Wessenger moves that paragraph 28 of subsection 91(1) of schedule 2 to the bill be amended by striking out "and for anything the registrar is required or authorized to do" in the fourth and fifth lines.

He further moves that subsection 91(1) of schedule 2 to the bill be amended by adding the following paragraph:

"28.1. Requiring persons to pay fees, set by the registrar or prescribed, for anything the registrar is required or authorized to do."

Mr Wessenger: This really authorizes the council to make regulations governing fees for purposes other than those specified.

Motion agreed to.

Mr J. Wilson: As that amendment has been adopted, I will change my motion just slightly, Madam Chair. I think it will now have to become 28.2, not 28.1, since we just put in a 28.1.

The Chair: That is correct.

Mr J. Wilson moves that subsection 91(1) of schedule 2 to the bill be amended by adding the following paragraph:

"28.2. Requiring members to pay a prescribed annual levy to the survivors compensation fund and requiring members to pay prescribed penalties for the late payment of the levy."

Mr J. Wilson: I move that this be stood down in accordance with other amendments along the line of the sexual abuse debate.

The Chair: I have a motion that this amendment be stood down to the appropriate time.

Motion agreed to.

The Chair: Mr Wessenger moves that paragraph 30 of subsection 91(1) of schedule 2 to the bill be struck out and the following substituted:

"30. Requiring members to have professional liability insurance satisfying prescribed requirements or to belong to a prescribed association that provides protection against professional liability and requiring members to give proof of the insurance or membership to the registrar in the prescribed manner."

Mr Wessenger: This amendment was recommended because professional liability insurance does not accurately describe the Canadian Medical Protective Association that medical doctors belong to for the purposes of protection against professional liability.

Motion agreed to.

The Chair: We cannot at this time move section 91 because we have stood down some parts of it, so that all of section 91 will be stood down, Mr Wessenger, until such time as—we, of course, have a motion to stand down section 91 to be dealt with at the appropriate time.

The Chair: The clerk will prepare for all members of the committee a list of all of those items which have been stood down. Everything else to this point has been dealt with.

Title agreed to.

Le titre est adopté.

The Chair: I would just point out regarding the motions "Shall the bill, as amended, carry?" and "Shall it be ordered?" that it has been agreed, and we have a motion, that this will not take place until Bill 64 has been ordered. Agreed? Agreed.

Mr J. Wilson: Can I just ask for a clarification of that? I did miss the introductory remarks of the parliamentary assistant earlier today. Will we proceed tomorrow with the

stood-down amendments in the omnibus Bill 43 or are we setting them aside until after Bill 64? Is that what you just said?

The Chair: No, what I understand we are doing is that the ones that have been stood down will be stood down until next Monday when the minister will be here. The last two that I mentioned, "Shall the bill carry?" and "Shall it be ordered?" have been deferred until Bill 64 has been ordered. Is that correct, Mr Wessenger?

Mr Wessenger: Yes, that is correct.

The Chair: As well, the amendments regarding the native motion that has been placed will also be after Bill 64 has been ordered. Is that clear, as far as process is concerned?

Mr J. Wilson: Thank you. I appreciate that clarification.

The Chair: In light of the motions and the schedule, the committee must decide what if anything it would like to do tomorrow. Mr Wessenger, would you suggest that we stand adjourned until next Monday?

Mr Wessenger: Yes, I think we should stand adjourned until next Monday.

Mr Cordiano: As a matter of fact, there is very little to deal with other than the things that have been stood down, amendments. I think we should just meet on Monday and deal with those.

The Chair: It would be helpful, however, as we seem to be moving right along, if all three caucuses, or the government and the two caucuses, could table their amendments to the first few other bills by Friday of this week, so they can be circulated. Then we hopefully will be ready to deal with them Monday or Tuesday, depending on how discussions go, but I think there is an interest. So could we try to have all amendments to the first five bills to the clerk by Friday? That would be Bills 44 to 49 inclusive. Is that possible? Or as many as possible ready for Friday.

Mr J. Wilson: Certainly the first three, but when you get into Bills 47, 48, 49 and the dentistry stuff, it does get a bit complicated. Perhaps we could at least agree on the first three.

The Chair: Agreed for the first three.

Mr Cordiano: Okay, agreed. I will check on that, but that is fine.

The Chair: It is a request, it is not a motion, that we try to have all of the amendments for the first three bills, Bills 44, 45 and 46, tabled with the clerk by this Friday so they can be circulated. The committee stands adjourned until Monday following question period, approximately 3:30. Thank you all.

The committee adjourned at 1754.

CONTENTS

Monday 30 September 1991

Regulated Health Professions Act, 1991, and companion legislation / Loi de 1991 sur les professions de la santé réglementées
et les projets de loi qui l'accompagnent S-825

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Chair: Caplan, Elinor (Oriole L)
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Beer, Charles (York North L)
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Hope, Randy R. (Chatham-Kent NDP)
Malkowski, Gary (York East NDP)
Martin, Tony (Sault Ste Marie NDP)
McLeod, Lyn (Fort William L)
Owens, Stephen (Scarborough Centre NDP)
Wilson, Jim (Simcoe West PC)
Witmer, Elizabeth (Waterloo North PC)

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Monday 7 October 1991

Standing committee on social development

Regulated Health
Professions Act, 1991
and companion legislation

Assemblée législative de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le lundi 7 octobre 1991

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent



Chair: Elinor Caplan
Clerk: Lynn Mellor

Présidente : Elinor Caplan
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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 7 October 1991

The committee met at 1530 in room 151.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

The Chair: The clerk has provided a list of all those sections that have been postponed and they are on the paper before you that says, "Bill 43, Regulated Health Professions Act, 1991, Postponed Items." As well, there is a package of proposed amendments to Bills 43, 44 and 45 and you will be receiving a package to add to that. At this time the clerk is distributing them.

We are going to begin today, with the consent of the committee, on the postponed items list at section 6 and deal with the clauses in numerical order. All agreed that we proceed in that way? That is the normal procedure for a committee.

Section/article 6:

Mr Wessenger: I would ask that the subsection 6(3) amendment be withdrawn. The purpose of withdrawing it is that we are not going to have a patient relations monitoring board. There is going to be another procedure to deal with the matter of monitoring the patient relations committee. It is going to be introduced at a later date.

The Chair: Shall section 6 stand as written in the bill?

Section 6 agreed to.

L'article 6 est adopté.

Mr Wessenger: I suggest that section 11 be reopened and heard with section 81.

The Chair: We have a request from the parliamentary assistant that consideration of section 11 be postponed until we have dealt with section 81.

Agreed to.

The Chair: Back to the agreed-upon agenda. We have now postponed section 11, carried all sections between the beginning of the bill and section 26, which we are now at. Is that your understanding?

Mr Wessenger: That is my understanding.

The Chair: The reason I want to be really clear on this is that when dealing with postponed items there is sometimes a little bit of, I would use the word "confusion" lightly, about exactly where we are. So for the record I want to be clear that everyone knows where we are and

how we got there. Agreed. We are now beginning section 26, which was postponed.

Section/article 26:

The Chair: Mr Wessenger moves that paragraph 1 of subsection 26(2) of the bill be struck out and the following substituted:

"1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis."

Mr Wessenger: I think it is fair to say that the whole question of subsection 26(2), as set out in the bill, has been a matter of concern to many individuals. There have been certain perceptions with respect to the meaning of that clause as set out in the original bill, so this amendment is to make it clearer with respect to the intended intention that the unregulated groups would not be affected in their counselling role with respect to this clause.

The first aspect of the amendment is to substitute the word "diagnosis" for the word "conclusion." The purpose of this is because "diagnosis" is a much narrower and more precise term than "conclusion" and there was some concern expressed that the word "conclusion" could be an opinion given after an assessment or an observation made from an assessment. To clarify that, the word "conclusion" is being replaced by the word "diagnosis." We think this makes it much clearer that there is no restriction on communicating results of assessments.

The second aspect is to remove the word "dysfunction" from the definition. This narrows the restriction to diseases and disorders. This was done because dysfunctions are often identified by assessing patients. Therefore, it is doubly clearer that assessment results may be communicated.

Although it is not the subject matter of this particular amendment, there is a further amendment I would like to refer to which is related to subsection 26(2). That is the proposed subsection 28(2). Subsection 28(2), which we propose to introduce, makes it clear that, "Subsection 26(1) does not apply with respect to a communication made in the course of counselling about emotional, social, educational or spiritual matters as long as it is not a communication that a health profession act authorizes members to make." Again, this will help to clarify the situation with respect to the whole question of counselling. I think the amendment to subsection 26(2) has to be considered in connection with the amendment, subsection 28(2).

Mr J. Wilson: I just wonder if members would note, three pages following, that the PC amendment from my caucus only varies from the government's amendment to subsection 26(2) in that we have inserted the word "medical"

in front of the word "diagnosis." I am wondering if that would be a friendly amendment to the parliamentary assistant, given that a number of the unregulated health professions, the coalition of churches and the Coalition of Unregulated Health Professionals really believe very strongly that we must make it clear in this legislation that we are referring to a prohibition on medical diagnosis.

We feel very strongly in our caucus that this would help, as the parliamentary assistant has just said, to strengthen the clause to ensure that anyone picking up a copy of the bill and reading it would understand we are referring to medical diagnosis. I wonder, Madam Chair, if that would be a friendly amendment.

The Chair: No, Mr Wilson, it would not. The notion of a friendly amendment is not parliamentary in this context. It is appropriate, if you wish, to move your amendment to the government amendment. It can then be discussed and voted on appropriately.

1540

The Chair: Mr Wilson moves that paragraph 1 of subsection 26(2) of the bill be struck out and the following substituted:

"1. Communicating to the individual or his or her personal representative a medical diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis."

Mr Wessinger: If I might speak to that, the reason we do not consider it a friendly amendment is that it makes medicine the reference point, which is objectionable to other regulated professions and against the philosophy of the whole legislation, which is to recognize other professions in the delivery of health care, besides the whole question of medicine.

It would be difficult to apply to the authorized acts of chiropractic, chiropody, dentistry, optometry and psychology. Actually we did look at that whole question at an earlier stage in the manner of attempting to see if there would be some method of covering this aspect and defining each one of those diagnoses specifically, but the problems were too great to really proceed along that way. Therefore, I cannot support that amendment.

Mr J. Wilson: Speaking to it further, I agree it would be difficult, to some degree, to amend the other acts, but not impossible. It would make it clear, I think, that we are referring to medical diagnosis. A number of groups have asked for this. I do not think the legal hurdles are so great that we cannot get around them and adapt the other legislation to this amendment. It would seem to me that it is an appropriate amendment.

The government should be defining in the legislation what "diagnosis" means. You will admit, I think, parliamentary assistant, that many groups that appeared before this committee used the terms "assessment" and "diagnosis" interchangeably. Perhaps if you will not accept our amendment, which we feel strongly about, you will consider putting into the legislation a definition of what you are referring to as

"diagnosis" so that it is clear to everyone who picks up this act what exactly the government's intention is here.

Mr White: I wonder if I could seek some clarification on this point from the parliamentary assistant, with the consultation available to him. As it presently stands, diagnosis is limited to this very specifically limited number of practitioners. Is that right?

Mr Wessinger: That is correct.

Mr White: Is the quality or the nature of their diagnosis profession-limited, ie, do optometrists have a specific area?

Mr Wessinger: Yes, they do. There are specific areas set out with respect to each profession.

Mr White: Along those lines, is it also true that no other of those professions may make a diagnosis in that area? Thus, a medical doctor could not make an optometrist's assessment and a medical doctor could not make a psychological assessment—or diagnosis, excuse me. It is an important distinction, I understand.

Mr Wessinger: Yes. However, certainly the medical profession has a broad diagnostic power because of the various medical specialties.

Mr White: I understand that, but under the law, is it legal for a medical doctor to make a psychological diagnosis or assessment, whichever phrase you want to use?

Mr Wessinger: Yes, it would be.

Mr White: It would be illegal?

Mr Wessinger: No, it would be legal for a doctor to make a psychological assessment under the legislation.

Mr White: A medical doctor could make a psychological assessment.

Mr Wessinger: We might have counsel give some clarification here.

Ms Bohnen: In this legislation, physicians are authorized to diagnose all diseases and disorders. Professions like optometry, psychology and chiropody diagnose subsets of that, so there are certain kinds of diagnoses a physician can make, that a psychologist is authorized to make, or an optometrist is authorized to make. Certainly, psychologists do many things that physicians do not, but the only kind of thing you are talking about regulating at the moment is a certain kind of diagnosis.

Mr White: But within the context of this act, psychologists who are trained to use certain kinds of tools are the only people who are allowed to use those tools, right?

Ms Bohnen: No.

Mr White: Do you mean that under this act medical doctors who have absolutely no training whatsoever in using psychological tools are authorized to use them?

Ms Bohnen: I think you are talking about psychological testing. Psychological testing is not controlled by this legislation, but diagnosis is controlled.

Mr White: The diagnosis would derive from that testing, though.

Ms Bohnen: It may or it may not. For what psychologists are authorized to diagnose, perhaps I can just refer you to the proposed Psychology Act. For some of those things

psychological tests would be a useful tool and for other things they would probably be quite useless. What psychologists will be authorized to diagnose, or at least to communicate diagnoses about, are neuropsychological disorders or psychologically based psychotic-neurotic or personality disorders. Physicians in this legislation are authorized also to communicate diagnoses about all of those things, but that says nothing about whether a physician is qualified to administer psychological tests. You are quite right that they do not administer psychological tests.

Mr White: But it is through psychological tests that psychologists can determine neuropsychological dysfunctions and learning disorders and a range of other difficulties. It is through those technologies. I guess what strikes me as unusual here is that you are saying they are allowed to use diagnoses that they are not trained to. I am sorry, go ahead.

Mr Owens: More to the point of Mr Wilson's comment around the issue of diagnosis and assessment in terms of the language usage, I think Mr Wilson hits on an interesting point when he says this terminology has been used interchangeably.

That is the crux of the problem, that the regulated professions that would be covered by the proposed government clause would be adequately protected. I do not think you can read this in isolation from the harm clause proposed and accepted by the official opposition that taken in its whole context, the unregulated professions are also protected through the harm clause with its various exemptions.

Mr J. Wilson: Just to come back to the comments by the parliamentary assistant, who said that perhaps our amendment inserting the word "medical" in front of the word "diagnosis" would somehow give supremacy back to physicians, I do not believe that to be the case, because you also note that my comments at the beginning of these clause-by-clause proceedings were that we would be giving the act of diagnosis within the scope of practice of audiology and speech-language pathology. So we are certainly not giving supremacy to physicians and I do not like the spin that has been put on that by the parliamentary assistant. I do not think it is a valid argument for not allowing the words "medical diagnosis" to be inserted in the legislation.

Mr Wessinger: Perhaps I might refer to counsel on this.

1550

Ms Bohnen: I would like to get back to Mr White's point, because left the way it was it may be troubling to some members of the committee. It is the responsibility of the College of Physicians and Surgeons of Ontario to ensure that physicians only diagnose within their own individual competence. That competence in most cases, I would guess, does not include using the arsenal of psychological tests that psychologists use, but physicians diagnose in their way just as psychologists diagnose in their way.

What these bills are trying to do is to ensure that both groups are diagnosing the kinds of conditions they are competent to diagnose, but it does not suggest that physicians do what psychologists do, or that psychologists do it the same way physicians do it. Each profession is distinct and it is up to its regulatory body to ensure that the membership

as a profession diagnoses in the ways they are competent to do so.

Mr Hope: Just listening to the conversation about inserting the word "medical," is it not true that some of the regulated professions concentrate on non-medical areas, so they would not have the ability to communicate that area?

Mr Wessinger: I think it is a fair reflection that in our opinion the insertion of the word "medical" would make it somewhat difficult for the other professions, yes.

Mr J. Wilson: I would be difficult but not impossible to amend, for example, the Audiology and Speech-Language Pathology Act to ensure that they are able to carry out the same medical diagnosis and give them that controlled act. I think the intent of the amendment is to ensure that all those unregulated professions understand that what we are trying to prohibit here is their communicating an actual medical diagnosis, and by inserting the word it makes that clear.

I go back to the many witnesses we had before this committee who used the word interchangeably and there is a lot of confusion out there. I have discussed this with the College of Physicians and Surgeons and they are comfortable with it as long as we take steps to make it clear which professions we also want to be carrying out a medical diagnosis. For instance, we proposed that speech-language pathologists be able to do that because it was clear in their testimony that they do conduct and are asked to conduct a medical diagnosis within their scope of practice.

Mr Hope: In response to what he is saying, and I guess to the parliamentary assistant, under subsection 28(2), dealing with the changes that will be made on educational and spiritual matters, would that not then alleviate the pressures put on about those able to communicate diagnosis? We are talking about educational. Educational may be education about a disorder or a dysfunction they may have through the communication process.

Mr Wessinger: It was felt that amendment would clarify the situation with respect to counselling in the educational and social areas. That certainly was the purpose of putting forward that amendment to add subsection 28(2), to combine it with this definition. We are of the opinion that this adequately protects the unregulated professions in carrying out their counselling functions.

Mr J. Wilson: In fact it was my colleague the member for Burlington South who suggested we put in the word "educational." We agree that is helpful, but we also think that inserting the word "medical," as has been asked by us, by many of the unregulated professions and by a coalition of churches, would also be very useful and work together as a package to ensure there is no confusion out there about what the intent of the legislation is.

Mr Owens: I guess I am hung up on the definition of "diagnosis" qua diagnosis because I do not believe that practitioners like speech-language pathologists actually diagnose in the strictest sense of the word. They clearly assess and then they communicate that assessment. The amendment or clause proposed by the parliamentary assistant clearly allows practitioners like speech-language pathologists to continue as they have done for years without any effect on their practice. Again, I refer back to the harm

clause which covers the unregulated practitioners through the exemption process.

Mr J. Wilson: To that point, I think you would find speech-language pathologists disagree with you, Mr Owens. Take the case of chiropractors. The Workers' Compensation Board, clearly testifying before this committee, asked for diagnosis from—and I asked them specifically, "Do you mean 'diagnosis' in the way the College of Physicians and Surgeons would use the term?" They said, "Yes." To me that is a medical diagnosis. It is asked for and there are certain groups out there that do perform that.

Mr Owens: There is no argument.

Mr J. Wilson: It sounded like that was the argument about speech-language pathologists.

Mr White: We would like to speak on this. As I stated earlier, I obviously have some concerns about the whole nature of how "diagnosis" is defined, but limiting it to "medical diagnosis" is, I think, even more problematical because you have a number of professions that are or will be regulated, some of which will and do have specified scopes of practice that include diagnosis. They may not consider them to be medical diagnoses, though. I doubt whether a psychologist, for example, would consider himself to be a medical practitioner, nor, necessarily, a chiropractor or an optometrist, except when they testify before a committee such as this.

To all intents and purposes, when you specifically limit it to medical diagnoses, I think that further confuses people in terms of what diagnoses are covered by that term and it also confuses the professions involved. I hope that by leaving it as the government's parliamentary assistant has suggested, we would have the scope in the future to include other groups that have competencies to make assessments, diagnoses, whatever phrase one wants to use and be regulated by this same process. However, if it was to move to a medical diagnosis, it would by its nature refer only to one of those professions, that of the medical doctor. I think that is overly limiting.

Mr Cordiano: We have had a fair discussion on this and I move that we proceed with this matter and consideration and take a vote by putting the question before the committee.

The Chair: Thank you. I will entertain the motion you have made. I believe, however, before we vote on the amendment and the amendment to the amendment, your caucus has a motion you wish to withdraw on this particular aspect. Did you wish to do that at this time?

Mr Cordiano: We have a motion on section 26.

The Chair: To paragraph 26(2)1; how would you like to deal with that?

Mr Cordiano: We withdraw it.

The Chair: You wish to withdraw that. Do you want to speak to the withdrawal, Mr White?

Mr White: No, I want to speak to the closure motion.

The Chair: Just a moment, please.

Mr Cordiano: I also have another motion which I guess would follow after this.

The Chair: I will call that at the appropriate time. It is not at this moment. I have Mr Wilson. Is there discussion?

Mr J. Wilson: I will pass. I am fascinated with Mr White's insights on this legislation.

The Chair: I have been advised by the clerk that a motion to call the question is not debatable.

Mr White: My question is whether it is in order.

The Chair: According to the clerk it is in order. I now call the question on the amendment to the amendment which has been placed by Mr Wilson. All those in favour of Mr Wilson's amendment? Any opposed?

Motion negatived.

The Chair: I now call the government motion which is an amendment to paragraph 26(2)1. All those in favour of the government's amendment? Any opposed?.

Motion agreed to.

1600

The Chair: Mr Wessenger moves that subparagraph ii of paragraph 6 of subsection 26(2) of the bill be struck out and the following substituted:

"ii. beyond the point in the nasal passages where they normally narrow."

Mr Wessenger: The purpose of this amendment is to clarify the language. The restriction is with respect to inserting instruments in the nasal passage.

Motion agreed to.

The Chair: Mr Wessenger moves that paragraph 11 of subsection 26(2) of the bill be amended by inserting after "orthodontic" in the second line "or periodontal."

Mr Wessenger: This amendment extends the controlled act to cover periodontal appliances.

Motion agreed to.

The Chair: Mr Cordiano moves that section 26 of the bill be amended by adding the following subsection:

"(4) Subsection (1) does not prevent an individual from communicating an opinion or result of an examination within the competence of the individual."

Mr Cordiano: As members would recall, we heard a great deal of concern by unregulated professionals with respect to the diagnosis clause referring back to the word "dysfunction" and rendering them incapable of communicating an assessment. This is an effort to clarify the difference between a "diagnosis" and an "assessment" being communicated by the mostly unregulated professionals.

Mr Wessenger: I would like to speak against the motion. We feel it is not necessary because the amended diagnosis clause makes it clear assessments may be communicated; that is, the control on communication relates to diagnosis only. It is clear that if an opinion is a diagnosis, it should not be communicated by unauthorized persons. Therefore, for that reason we would not support it.

Motion negatived.

The Chair: Mr J. Wilson moves that section 26 of the bill be amended by adding the following subsection:

"(4) Health care services in subsection (1) does not include an act done in the course of physically assisting a

person with a disability with his or her routine activities of living if the act is done on the person's consent and the person, if able, would do the act for himself or herself."

Mr J. Wilson: The intent of the amendment is to make it very clear that attendant care is performed at the direction of the recipient of that care.

Mr Wessinger: I would like to speak against the amendment because it is more restrictive than the government amendment that is proposed in clause 28(e). It should be noted that the language in clause 28(e) has been approved by all the interested groups. I think it is appropriate that should be the clause that is passed, in view of the agreement by all interested groups. I think it is inappropriate to add the consent requirement here. I think it is presumed that all services require a valid consent of the recipient of the service or substitute decision-maker. That is a basic assumption of all the acts. It should not be set out here.

Mr J. Wilson: I do not understand why the government would be voting against this in that it actually strengthens the government's amendment to section 28 and makes it clear and concise. It is exactly what many of the groups asked us to do in the sense of making sure the recipient of the attendant care does direct that attendant care and gives consent to that care.

Motion negatived.

Section 26, as amended, agreed to.

L'article 26, modifié, est adopté.

Section/article 28:

The Chair: I believe section 28 is the next postponed section.

Mr Wessinger moves that section 28 of the bill be amended by adding the following clause:

"(e) Assisting a person with his or her routine activities of living and the act is a controlled act set out in paragraphs 5 or 6 of subsection 26(2)."

Mr J. Wilson: In light of my previous defeated amendment dealing with attendant care, I will certainly be supporting the government's amendment in this case.

Motion agreed to.

The Chair: Mr Wessinger moves that section 28 of the bill be amended by adding the following subsection:

"(2) Subsection 26(1) does not apply with respect to a communication made in the course of counselling about emotional, social, educational or spiritual matters, as long as it is not a communication that a health profession act authorizes members to make."

Mr Wessinger: I referred to this as being complementary to subsection 26(2), making it clear that it does not affect counselling in the areas of emotional, social, educational and spiritual matters.

Mr White: I am curious. We have a reference here to counselling and we have a distinction that the parliamentary assistant has made between assessment and diagnosis, something which, in the course of my career, I have never been quite clear on, and I am glad the act makes it clear. But it is "not a communication that a health professions Act authorizes members to make." In the case of someone who was employed by a health facility, such as a hospital

or a clinic, how would there be a distinction made between a communication that a medical doctor makes, or a psychologist, or a social worker, or a nurse, about the psychosocial wherewithal of a client, patient, person or whatever the phrase is?

Mr Wessinger: There are, as you know, certain controlled acts set out, and each act that deals with a specific profession sets out the authorized acts that profession may do. Of course, all the authorized acts are set out for the medical profession. With respect to the psychologists, counsel has already indicated the area in which they can exercise a controlled act, and the controlled acts are set out, and will be set out, for the other professions.

There will be some amendments coming through with respect to these other acts and pertaining to other professions, but I do not think at this time it is appropriate to discuss the authorized act for each specific profession because it will be dealt with specifically as we reach that act.

Mr White: I would certainly agree with you on that point. However, at the moment there are many professions which are not regulated within the spirit or context of these acts, and inasmuch as numerous people are employed in Ministry of Health funded facilities, would it not be problematic for them to pursue their practice if they communicate anything to their clientele or patients?

1610

Mr Wessinger: It is only a communication of a diagnosis. It is very clear in the act that we have the words "diagnosis" and "assessment," and it is very clear that a court would give different meanings to those words "diagnosis" and "assessment." There is nothing that restricts any regulated or unregulated person from communicating an assessment.

Mr J. Wilson: I have a question for the parliamentary assistant. When my colleague from Burlington South suggested the word "educational" be inserted in here, I thought there was some level of discomfort expressed by the government. I cannot quite recall for the life of me right now what exactly the discomfort was. Does the parliamentary assistant have any comments on the word "educational" at this point?

Mr Wessinger: The language is satisfactory, but I will ask counsel to explain how this bit differs from the prior amendment in the harm clause.

Ms Bohnen: When you first saw this language, it was an exception to the harm clause that was discussed last week. Instead of referring to counselling about emotional, social, educational or spiritual matters, it said "counselling of an emotional, social, educational or spiritual nature." The government's concern was that saying it was of a "nature" was not an accurate expression of what was meant.

For example, counselling of an emotional nature might be counselling in which people cried and people laughed and that was not what you intended. We did not even know what counselling of a social nature would be. Does that mean counselling with a gathering of people? The government members thought that what was really meant was emotional, social, educational or spiritual matters, and that is reflected in this language here. So it was not the word, per se; it was just the word "matters" instead of "nature."

Mr J. Wilson: Thank you, counsel. With the new wording and that explanation, we will be supporting this amendment.

Motion agreed to.

Section 28, as amended, agreed to.

L'article 28, modifié, est adopté.

Section/article 28.1:

The Chair: Mr Wessenger moves that subsection 28.1(4) of the bill, as added by the committee on September 30, 1991, be struck out and the following substituted:

"(4) Subsection (1) does not apply with respect to counselling about emotional, social, educational or spiritual matters."

Mr Wessenger: I think we need unanimous consent to consider this. This relates to the harm clause.

The Chair: We have no copies.

Mr J. Wilson: I guess in light of the clause just passed, this would be a housekeeping matter with regard to the harm clause.

Mr Wessenger: Yes, that is correct.

The Chair: Has it been read into the record in its entirety?

Mr Wessenger: Yes, I just read it in.

The Chair: It will be copied and distributed. Do you have a copy of it, Mr Wilson?

Mr J. Wilson: I have a copy and we have no objection.

Motion agreed to.

Section 28.1, as amended, agreed to.

L'article 28.1, modifié, est adopté.

The Chair: Mr Cordiano moves that the bill be amended by adding the following section:

"28.2. Sections 26 and 28.1 do not apply with respect to assistance with the activities of daily living rendered to a person with a disability under a contract with that person."

Mr Cordiano: The exception follows on what was discussed earlier with respect to disabled persons. It is an effort to ensure that we do not prevent what normally took place with respect to having that kind of service provided for a disabled person continuing to take place and that the disabled person would not be denied those services. This is an effort to ensure that it is followed and provides for the disabled person to have an ongoing relationship with the person who provides the service. We heard quite a bit about that from the disabled community and this attempts to clarify that position.

Mr Wessenger: I would like to speak against the motion. We have already passed clause 28(e), which was the clause that had been agreed to by all interest groups, and consequently I cannot support this motion. We feel it is more restrictive than the government's attendant care exception and therefore it is less acceptable to persons affected. Also, it requires a recipient of a service to have a disability and to enter into a contract. The evidence of the persons at committee, I understand, would make this unacceptable to them. There may be a contract, of course, between a social agency and an attendant or between an attendant and a recipient's family.

Mr J. Wilson: To follow up on the parliamentary assistant's comments, given that the committee defeated our attendant care motion and that we have agreed to pass the government amendment, I think Mr Cordiano would perhaps be in line to withdraw this amendment. It is redundant at this point.

Mr Cordiano: I think one could argue that there is clarity in what the government has proposed. I happen to feel that it is not clear enough and therefore put forward this amendment. I think we should take a vote on this, and that is my position.

The Chair: Any further discussion? I will call the question on the amendment. All those in favour of the amendment? Any opposed?

Motion negated.

Mr. J. Wilson: I cannot believe I voted with you guys.

The Chair: Thank you very much, Mr Wilson. We move on now to proposed section 31.1. I believe there was agreement that this would be held down.

Mr Wessenger: Yes, held down.

The Chair: There was agreement that this would be held till the end. Okay, I think all the others are also—

Mr Wessenger: No.

The Chair: Which other one?

Mr Wessenger: Subsection 36(2).

Section/article 36:

The Chair: Subsection 36(2) can be dealt with today.

Mr Wessenger: moves that subsection 36(2) of the bill be amended by inserting after "29" in the second line "29.1."

Mr Wessenger: This is just a housekeeping amendment that adds section 29.1 to the offence provision.

Motion agreed to.

Section 36, as amended, agreed to.

L'article 36, modifié, est adopté.

The Chair: Section 39 has been held down until the end. I believe now we are at schedule 2.

Schedule/annexe 2:

Section/article 1:

The Chair: Mr Wessenger moves that subsection 1(1) of schedule 2 of the bill be amended by adding the following definition:

"'patient relations program' means a program to enhance relations between members and patients."

Mr Wessenger: This is a definition section related to the new patient relations committee and program that is to be established.

Motion agreed to.

1620

Section/article 9:

The Chair: I believe, Mr Wessenger, you have an amendment to section 9.

Mr Wessenger: moves that section 9 of schedule 2 of the bill be amended by adding the following paragraph:

"7. Patient relations committee."

Mr Wessenger: This adds the patient relations committee to mandatory committees of each college.

Mr J. Wilson: This perhaps would have been appropriate on the previous amendment. This deals with the whole area of the CPSO sexual abuse task force recommendations and I thought—correct me if I am wrong, Madam Chair—we had agreed when we last met that we would stand down the whole discussion on a patient relations committee until much further in the process and that we would not be dealing with it today.

Mr Wessenger: It is my understanding that the only matter that was stood down until the end of all the bills was the matter related to native affairs. I believe this was to be stood down to be considered with the diagnosis.

Mr J. Wilson: No. Sexual abuse was also, or at least that is the agreement I agreed to. Otherwise, I would not have agreed. Perhaps you would like to check the transcript.

The Chair: I believe there was agreement by committee members that matters relating to sexual abuse would be stood down until after Bill 64.

Mr J. Wilson: That was my understanding, so perhaps the previous amendment, which we just did, also has to be stood down.

The Chair: Subsection 1(1), patient relations program.

Mr J. Wilson: It is a little different from the patient relations committee.

The Chair: That is correct.

Mr J. Wilson: So it is just this particular amendment.

Mr Wessenger: Could I just speak to this whole question? If the case is that we did agree to stand it down, I would ask that the committee might reconsider that aspect on the basis that we are not going to be in the position to have the final report with respect to the matter of sexual abuse by the time we finish these bills. Even if the report was finished, the consultation with all the groups would not be in at that stage. Certainly if it is the committee's wish to stand it down to the end, it can be, but I do not see any particular purpose in standing it down to the end of the other bills because we are going to be in no better position to consider the matter at that stage than we are at the present time.

The Chair: What I am hearing from Mr Wessenger is that we reconsider the decision regarding the timing related to issues around sexual assault. It is my understanding that the committee agreed to stand down everything that was related to the native band question and to sexual assault pending the completion of Bill 64. We have no idea what the timing is going to be regarding the completion of Bill 64. We have a request from the parliamentary assistant. I am going to ask for speakers on this matter and see how the committee feels about it before we proceed any further.

Mr J. Wilson: To be perfectly frank about it, we are not prepared to discuss the patient relations committee today because review of the transcript would clearly indicate that we agreed among committee members that this would be stood down until after Bill 64. I have a number of consultations and commitments coming up this week and next

week around this very issue and cannot proceed today without hearing from people on how they feel about this.

My gut reaction on this is it just absolutely flies in the face of the logic the parliamentary assistant just presented to the committee. We are now setting up a huge bureaucracy in terms of a patient relations committee and he says, "Actually we are not really prepared to deal with the issue, but let's set up this bureaucracy anyway." Rather than getting me really angry and starting into this whole thing, it would be best for all committee members' good health that we stick to our original agreement and deal with this after Bill 64. We will have a little more time to consider it.

The Chair: In light of Mr Wilson's comments and the fact that there seems to be a number of people who want to speak on this, I would like to suggest that we adhere to the previous decision taken by the committee, that if there is a desire to discuss this further at another time, we can do so, but that we not deal with it today. Agreed?

Agreed to.

The Chair: Shall schedule 2, subsection 1(1), as amended, carry? That is the previous one, Mr Wilson. All in favour? Any opposed? That is carried.

We will stand down schedule 2, section 9.

Mr Wilson: I do not think your motion to schedule 2, section 24, relates to anything that has been stood down.

Mr White: Did we pass schedule 2, subsection 1(1)?

The Chair: Yes, we carried that.

Mr White: Are we then revoking that?

The Chair: No.

Mr J. Wilson: It relates to a different matter; similar name but a different matter.

Mr Hope: I would like a point of clarification for myself, under schedule 2, section 9, where it is dealing with the patient relations committee.

The Chair: That has been stood down. We are not dealing with that.

Mr Hope: That is what I wanted a little bit of clarification about. We are not creating a bigger bureaucracy; all we are doing is setting a committee in place. I am just wondering why we could not deal with this, because the content of the committee is then after, in detail later on.

The Chair: It is because it has been agreed by the committee on a previous occasion that it would be stood down pending the dealing with Bill 64. That agreement was unanimous by the committee. Mr Wilson has objected to dealing with the matter today, and I think it is a courtesy that we not go forward today.

Mr Hope: Okay.

Mr Wessenger: Madam Chairperson, I guess we could review the Hansard to confirm that there was that agreement on the record. I do not recall it, but it may be the case.

The Chair: Okay, we will get you a copy of Hansard, Mr Wessenger.

Section/article 24:

The Chair: Mr Wilson, do you want to move your amendment today on schedule 2, section 24?

Mr J. Wilson: Yes.

I move that subsection 24 of schedule 2 of the bill be amended by adding the following subsection:

"(4.1) Despite subsection (4), a panel shall be selected if the complainant has a disability and the complaint is recorded on a tape, film, disk or other medium."

This amendment had been presented earlier by myself. We were asked to do some rewording of it and we are bringing it back today reworded. I think I might have the wrong subsection. I have new wording on that—sorry, Madam Chair—that I should read in and retract the previous wording—I got my pages mixed up here—if that is permissible for the Chair. The wording I just read in is actually not the newest rewording.

The Vice-Chair: Mr Wilson moves that subsection 24(4) of schedule 2 to the bill be struck out and the following substituted:

"(4) A panel shall not be selected unless the complaint is in writing or is recorded on a tape, film, disk or other medium."

Mr J. Wilson: That is the new wording the committee had asked us to come back with.

Mr Wessenger: I would just like to confirm that the wording is satisfactory, so we will support the amendment.

Motion agreed to.

The Vice-Chair: Shall section 24, as amended, carry?

Section 24, schedule 2, as amended, agreed to.

L'article 24, modifié, est adopté.

1630

The Vice-Chair: Just bear with me as we get caught up on where we are. The next section relates to sexual abuse, which we will also stand down.

Mr J. Wilson: Can I make a comment here with the indulgence of the committee? Dealing with the next matter that was stood down that is not dealing with sexual abuse, I believe it is schedule 2, section 46, and it was a Progressive Conservative motion. We have not received back wording on that, through no fault of legislative counsel. The question, when we last debated who would pay for the copies of transcripts, did arise and we were asked to come back with wording. I think there was some agreement that perhaps patients should bear the cost of the transcript. We do not have that wording available today so I would ask the indulgence of the committee to stand that down until we bring back from counsel—

The Chair: Agreed to stand down schedule 2, section 46, Mr Wilson's amendment? Agreed.

The next relates to the patient relations committee. We will hold that down. It is a government motion on section 81. I would point out that the government has withdrawn the original motion as proposed and substituted different wording. The moving of it was postponed, so we will hold that, or do you want that on the record, Mr Wessenger?

Mr Wessenger: I think it should be on the record that we are withdrawing schedule 2, sections 81.1 to 81.4, as originally moved, and we will be substituting a new amendment.

The Chair: Do you want to read it in?

Mr Wessenger: Why do we not just read it in?

The Chair: Mr Wessenger moves that schedule 2 of the bill be amended by adding, before the heading "Miscellaneous," the following sections:

"Patient Relations Committee

"81.1(1) The council shall make regulations under paragraph 22.1 of subsection 91(1) prescribing a patient relations program.

"(2) The patient relations program must include measures for the prevention of professional misconduct of a sexual nature.

"81.2 The patient relations committee shall advise the council with respect to the patient relations program."

Is there agreement to stand that down until we deal with all matters relating to the patient relations committee and sexual assault issues in general? Agreed.

Mr Wilson, your amendment will also be stood down. The amendment to schedule 2, sections 81 to 81.4?

Mr J. Wilson: Agreed.

The Chair: You may want to have a look at that and make some changes in light of the government's amendment. The next one is also held down, subsections 85(3) and (4). Mr Wilson, that is held down.

Section/article 91:

The Chair: We now have a government motion that relates to the patient relations program. We have already dealt with one amendment relating to the program, as opposed to the committee. I think we can deal with this amendment today.

Mr Wessenger moves that subsection 91(1) of schedule 2 of the bill be amended by adding the following paragraph:

"22.1 prescribing a patient relations program;"

Mr Wessenger further moves that subsection 91(2) of schedule 2 of the bill be amended by inserting after 22 in the first line "or 22.1."

Motion agreed to.

The Chair: Shall schedule 2, subsection 91(1) and subsection 91(2), as amended, carry? All in favour? Any opposed? Carried.

Your motion to subsection 91(1), Mr Wilson, is stood down.

Mr J. Wilson: Yes.

Interjection.

The Chair: Just a minute. I should not have called for that subsection at this time. It was an error of the Chair. I ask for unanimous consent to reopen.

Agreed to.

The Chair: We will hold on the calling of that subsection until we have dealt with Mr Wilson's amendment to subsection 91(1), which will be held down. That concludes the items before us that we are able to deal with today on Bill 43.

Mr J. Wilson: May I make a suggestion? Through no fault of her own, the minister is sick today. Since originally we had thought we were going to be discussing a number of matters with her, perhaps we could adjourn at this time.

The Chair: Mr Wilson moves adjournment of the committee.

Mr J. Wilson: It is not debatable, but I would simply make the comment that going into Bill 44 at this time would not be appropriate, given that we need a little more time to prepare for it. I think I have the agreement of the Liberal caucus on that.

Mr Owens: Understanding that the motion to adjourn is not debatable, I have a copy of the Hansard of last week and if we could just adjourn for a break, I would like to be able to determine the agreement we had with respect to the issues of sexual abuse and patient relations, if that would be acceptable to the members.

Mr J. Wilson: I thought we solved that issue.

Mr Cordiano: I thought we settled it.

Mr J. Wilson: Notwithstanding the Hansard at this point, we have agreed to stand that down.

The Chair: Mr Wilson, the parliamentary assistant requested an opportunity to review the Hansard. We said we would make the Hansard available to him. I think it is perfectly appropriate for the committee to recess for five minutes and then discuss your motion to adjourn. We stand in recess for five minutes.

The committee recessed at 1637.

1645

The Chair: Mr Wilson had made a motion to adjourn. I will now entertain a vote on that motion, which is not debatable.

Motion agreed to.

The committee adjourned at 1646.

CONTENTS

Monday 7 October 1991

Regulated Health Professions Act, 1991, and companion legislation / **Loi de 1991 sur les professions de la santé réglementées**
et les projets de loi qui l'accompagnent S-84

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

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Vice-Chair: Cordiano, Joseph (Lawrence L)
Beer, Charles (York North L)
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Hope, Randy R. (Chatham-Kent NDP)
Malkowski, Gary (York East NDP)
Martin, Tony (Sault Ste Marie NDP)
McLeod, Lyn (Fort William L)
Owens, Stephen (Scarborough Centre NDP)
Wilson, Jim (Simcoe West PC)
Witmer, Elizabeth (Waterloo North PC)

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Tuesday 8 October 1991

Standing committee on social development

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Professions Act, 1991
and companion legislation

Assemblée législative de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le mardi 8 octobre 1991

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent



Chair: Elinor Caplan
Clerk: Lynn Mellor

Présidente : Elinor Caplan
Greffière : Lynn Mellor

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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at (416) 325-7400.

Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 8 October 1991

The committee met at 1530 in room 151.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY ACT, 1991

LOI DE 1991 SUR LES AUDIOLOGUES ET LES ORTHOPHONISTES

The Chair: The standing committee on social development is now in session. I understand there has been an agreement that we proceed today with Bills 44, 45 and 46. Discussions regarding outstanding matters on Bill 43 will come forward at a future time. Everybody should have a new, integrated package of proposed amendments. We begin with section 1.

Section/article 1:

The Chair: Mr Wessenger moves that the French version of section 1 of the bill be amended,

(a) by striking out "audiologues" in the definition of "ordre" and substituting "audiologistes"; and

(b) by striking out "d'audiologue" in the definition of "profession" and substituting "d'audiologiste."

Mr Wessenger: It is to comply with the language preferred by the college.

Motion agreed to.

Section 1, as amended, agreed to.

L'article 1, modifié, est adopté.

Section/article 2:

The Chair: Mr Wessenger moves that the French version of subsection 2(2) of the bill be amended,

(a) by striking out "audiologues" in the definition of "ordre" and substituting "audiologistes"; and

(b) by striking out "d'audiologue" in the definition of "profession" and substituting "d'audiologiste."

Motion agreed to.

Section 2, as amended, agreed to.

L'article 2, modifié, est adopté.

Section/article 3:

The Chair: Mr Wessenger moves that the French version of subsection 3(1) of the bill be amended by striking

out "d'audiologue" in the first and second lines and substituting "d'audiologiste."

Motion agreed to.

Section 3, as amended, agreed to.

L'article 3, modifié, est adopté.

Section/article 4:

The Chair: Mr Wessenger moves that the French version of section 4 of the bill be amended by striking out "d'audiologue" in the first and second lines and substituting "d'audiologiste."

Motion agreed to.

The Chair: Mr J. Wilson moves that section 4 of the bill be amended by adding the following subsection:

"(2) In the course of engaging in the practice of audiology or speech-language pathology, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to communicate a diagnosis identifying an auditory or speech and language disorder as the cause of a person's symptoms."

Mr J. Wilson: The reasoning behind the amendment is that we believe speech-language pathologists and audiologists do diagnose communication problems within their scope of practice. Currently, audiologists and speech-language pathologists routinely present conclusions to the patient or the patient's family and counsel them regarding the results of the assessment as part of the assessment process.

Speech-language pathologists and audiologists are trained to assess, diagnose and treat a very specific group of communication disorders and dysfunctions, as set out in their scope of practice. As the legislation is currently written, only physicians and psychologists would be allowed to communicate the conclusion of a hearing or speech-language assessment to the patient, even though they may not perform the assessment or be present during the assessment, they are not specially trained in the assessment of all communicative disorders or dysfunctions, they may not be involved in the design of a treatment program based on the assessment results and they may not be involved in the long-term treatment of the patient's communicative disorder or dysfunction.

Essentially, it should be obvious to all members of the committee that we strongly believe and feel there was a great deal of testimony before the committee that speech-language pathologists and audiologists should have the ability to diagnose and communicate that diagnosis and the result of their assessment to their patients directly without having to go through a general practitioner or physician.

Mr Wessenger: I oppose the amendment on the basis that, in our opinion, audiologists do not diagnose; audiologists assess. There is nothing in the legislation that prevents them from communicating their assessments and the results

of their tests to the patient; therefore, this amendment is not appropriate in the circumstances.

Mr J. Wilson: We had a number of letters from physicians—from the Toronto Hospital, for instance—attached to one of the briefs from the speech-language pathologists. They specifically said to the committee that they do diagnose and are asked to diagnose and communicate the results of their diagnoses to their patients. What is the government's response to that specifically?

Mr Wessinger: The government's response is that they do not diagnose. There has been a lot of loose language used with respect to the whole question of the meaning of "diagnosis." Many groups have said they diagnose, when the correct language is that they are doing assessments. We clearly set out in the act the fact that we have changed it from "communicating a conclusion" to "communicating a diagnosis." We made it very clear in the act that there is a difference between a diagnosis and an assessment. We believe that more than amply solves the problem with respect not only to the unregulated but also to the regulated groups, making it clear that assessments are different from conclusions.

Motion negated.

Section 4, as amended, agreed to.

L'article 4, modifié, est adopté.

Section/article 5:

The Chair: Mr Wessinger moves that the English version of section 5 of the bill be amended by striking out "audiologues" in the fourth line and substituting "audiologists."

Mr Wessinger further moves that the French version of section 5 of the bill be amended by striking out "audiologues" in the second line and substituting "audiologistes."

Motion agreed to.

Section 5, as amended, agreed to.

L'article 5, modifié, est adopté.

1540

Section/article 6:

The Chair: Mr Wessinger moves that clause 6(1)(a) of the bill be amended by striking out "at least six and no more than ten" in the first line and substituting "at least eight and no more than nine."

Mr Wessinger further moves that clause 6(1)(b) of the bill be amended by striking out "at least four and no more than six" in the first line and substituting "at least six and no more than seven."

Mr Wessinger: It gives effect to the government's decision to increase public representation on the college's council to just under half, as agreed with the college.

Mr J. Wilson: I will certainly be voting against this particular amendment, given our position that it would further erode the principle of self-regulation.

Mr Hope: With regard to the comment about the ability for self-regulation, I believe that as long as you have 50% plus one you still have the ability to self-regulate. You have the majority.

Motion agreed to.

Section 6, as amended, agreed to.

L'article 6, modifié, est adopté.

Section 7 agreed to.

L'article 7 est adopté.

Sections 8 to 14/articles 8 à 14:

Mr Wessinger: I would like to indicate to members that sections 8 to 14, inclusive, of this bill are now rendered unnecessary by reason of the amendment that was previously made by the Liberals, which provided that the matter would be dealt with by regulation.

The Chair: So you are moving that sections 8 through 14, inclusive, be deleted.

Mr Wessinger: Yes, I move that sections 8 through 14, inclusive, be deleted.

The Chair: Do you have something in writing for us?

Mr Wessinger: I do not know whether I have.

The Chair: You will have something in writing for us before the end of this meeting. Thank you.

Mr Wessinger: Okay.

The Chair: We have a motion to delete sections 8 to 14, inclusive. All in favour? Any opposed? That carries.

Motion agreed to.

Sections 8 to 14, inclusive, deleted.

Les articles 8 à 14, inclusivement, sont rayés.

Section/article 15:

The Chair: Mr Beer moves that subsection 15(1) of the bill be struck out and the following substituted:

"(1) No person other than a member shall use the titles 'audiologist,' 'speech-language pathologist' or 'speech therapist,' a variation or abbreviation or an equivalent in another language in the course of providing or offering to provide, in Ontario, health care to individuals."

Mr Wessinger: I have an amendment to that motion. We have a government motion.

The Chair: Mr Wessinger moves that subsection 15(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

That is the government motion in our package.

Mr J. Wilson: Had the government not moved that amendment to the amendment, I would have moved the amendment to the amendment. We totally agree.

The Chair: You also have an amendment here to subsection 15(1). Do you want to move it now?

Mr J. Wilson: I will withdraw our amendment at this point, since it is exactly the same as the Liberal amendment.

The Chair: Mr Wilson's motion is withdrawn.

Mr Malkowski: I think it is important that those titles be very clear to avoid confusion in the public. I strongly encourage our members to support the motion.

The Chair: Any further discussion? First is the amendment to the amendment.

Motion agreed to.

The Chair: To Mr Beer's amendment?

Motion agreed to.

The Chair: Mr Wessenger moves that the French version of subsection 15(1) of the bill be amended by striking out "audiologue" in the second line and substituting "audiologiste."

Mr Wessenger further moves that the French version of subsection 15(2) of the bill be amended by striking out "d'audiologue" in the third and fourth lines and substituting "d'audiologiste."

Section 15, as amended, agreed to.

L'article 15, modifié, est adopté.

Sections 16 and 17 agreed to.

Les articles 16 et 17 sont adoptés.

Section/article 18:

The Chair: Mr Wessenger moves that section 18 of the bill be amended by striking out "college" in the third line and substituting "council" and by striking out clause (b).

Mr Wessenger: This amendment is necessary because the council is the college body that makes regulations.

Section 18, as amended, agreed to.

L'article 18, modifié, est adopté.

Sections 19 and 20 agreed to.

Les articles 19 et 20 sont adoptés.

Section/article 21:

The Chair: Mr Wessenger moves that section 21 of the bill be amended by adding following subsection:

"(4) Despite subsection (1), section 81.1 of the Health Professions Procedural Code, as it applies in respect of this act, does not come into force until one year after this act comes into force."

Mr Wessenger: This gives the college one year after proclamation to establish a patient relations committee.

Mr J. Wilson: I am surprised the government is moving forward with this amendment today, because I thought we stood down and had some sort of an agreement yesterday that the patient relations committee would not be discussed in any of these bills for at least two weeks. I think I had a private agreement for at least two weeks; certainly my public agreement is till after Bill 64. But I am willing to wait at least two weeks till we have further consulted on the whole idea of a patient relations committee.

Mr Beer: I think we would want to discuss that issue when we are discussing all of the attendant issues and that we should stand this down until that time.

Mr Owens: Later on, when we have finished the actual passage of these sections, I will be moving a motion that we deal with this issue on the patient relations and sexual abuse two weeks from yesterday.

The Chair: Mr Wessenger, I hear consensus at committee that we defer consideration of this section for two weeks and deal with it at the same time. Mr Hope, do you want to speak against that?

Mr Hope: No. It is a concern that I have dealing with the issue around assistive devices, because we are talking, I

guess, about patient relations. I want to put a question about the assistive devices program to the parliamentary assistant. Is there an assessment ongoing on that assistive devices program, or will there be changes coming in the future?

Mr Wessenger: I am afraid I cannot say anything at this time on that matter. We do not really have the information available.

The Chair: Are you speaking in opposition to the deferral of section 21, Mr Hope?

Mr Hope: I had my hand up to comment on patient relations, and that is why I got this comment in on the assistive devices program.

The Chair: The problem is, it is not in order now to discuss the clause as there has been agreement by the committee that it be deferred for two weeks.

1550

Mr Hope: I did not hear anybody make the motion, so I asked the question.

The Chair: There has been agreement by the committee that this be deferred. There has been agreement on Bill 43 to defer everything related to a patient relations committee. That has been the discussion at the committee, so it would be more appropriate for you to engage in the debate at the time when this is discussed. That is why I am asking if what you want to do is speak against the deferral.

That being the case, I see agreement from the committee that section 21 be stood down and dealt with at the same time we deal with all other matters relating to sexual assault. I have a formal motion from Mr Owens that this be dealt with two weeks from yesterday. Is that agreed by the committee? That will be October 21, for any members of the public who are interested. The committee will be dealing with all matters related to sexual assault at that time, so we will stand down section 21.

Motion agreed to.

Section/article 22:

The Chair: Mr Wessenger moves that the French version of section 22 of the bill be amended by striking out "audiologues" in the second line and substituting "audiologistes."

Motion agreed to.

Section 22, as amended, agreed to.

L'article 22, modifié, est adopté.

The Chair: Mr Wessenger moves that the French version of the long title of the bill be amended by striking out "d'audiologue" and substituting "d'audiologiste."

Title, as amended, agreed to.

Le titre, modifié, est adopté.

CHIROPODY ACT

LOI DE 1991 SUR LES PODOLOGUES

Sections 1 and 2 agreed to.

Les articles 1 et 2 sont adoptés.

Section/article 3:

The Chair: Mr Wilson moves that subsection 3(2) of the bill be amended by striking out "1993" in the third line and substituting "1994."

Mr J. Wilson: The explanation is that the legislation disallows entrance to the College of Podiatry after July 31, 1993, and we are proposing that this not come into effect until July 1994.

Apparently podiatrists had an understanding with the Schwartz committee and the ministry that the effective date of the cap would be three years after the date on which the legislation was tabled, and that is July 1994. The delay is in bringing forward this legislation. By moving the date to 1994, all Ontario residents currently in a podiatry program would have the opportunity to return to practise in Ontario. The government should note that both podiatrists and chiroprodists have called for this amendment.

Mr Wessenger: I would like to oppose the amendment because I understand that it was not the agreement that it would be three years after the tabling of the legislation. I would like to point out that this amendment is not supported by the board of regents of the chiroprodists. They in fact oppose this.

With respect to the question of fairness, the government's policy has been well known for several years. In addition, by extending this we are providing additional costs to OHIP because podiatrists have billing privileges, so it would have a financial impact by adding one more year.

The Chair: Because there is a financial impact in this amendment, I would suggest that it is ultra vires and beyond the scope of this committee to include an amendment that would have financial impact, without the support of the government.

Mr J. Wilson: Madam Chair, it is impossible to move any amendment without the support of the government. They have the committee stacked.

The Chair: Because of the information from Mr Wessenger that this has financial implication, I declare that it is not a valid motion before the committee. Shall section—

Mr J. Wilson: Just let me point out to the committee that the Ontario chiroprodists' association does support this amendment. Perhaps the board of regents does not, but certainly the association does.

Section 3 agreed to.

L'article 3 est adopté.

The Chair: I think Hansard should note Mr Wilson's objection to section 3, since his amendment was ultra vires. I am sure it does.

Section 4 agreed to.

L'article 4 est adopté.

Section/article 5:

The Chair: Mr Wessenger moves that paragraphs 2 and 3 of subsection 5(1) of the bill be struck out and the following substituted:

"2. Administering, by injection into feet, a substance designated in the regulations.

"3. Prescribing drugs designated in the regulations."

Mr Wessenger further moves that paragraphs 3 and 4 of subsection 5(2) of the bill be struck out and the following substituted:

"3. Administering, by injection into feet, a substance designated in the regulations.

"4. Prescribing drugs designated in the regulations."

Mr Wessenger: This amendment rephrases the authorized acts authorizing members to administer specified substances and prescribe specified drugs. The amendment makes it clearer that the substances and drugs will be designated in regulations under the Chiroprody Act.

Mr J. Wilson: We do not have any particularly strong feelings about this amendment and we will support it. But we do feel strongly that chiroprodists should be able to communicate a diagnosis, unless it is the subject of the next amendment. But I thought it was appropriate to also mention it in this context here.

Motion agreed to.

The Chair: Mr Wilson moves that subsection 5(1) of the bill be amended by adding the following paragraph:

"1 Communicating a diagnosis identifying a disease or disorder of the foot."

Mr J. Wilson: We are proposing this amendment on behalf of chiroprodists because we believe they should be allowed to communicate a diagnosis identifying a disease or disorder of the foot. As a result of the changing demography in our society, an increasing number of chiroprodists are practising in community-based clinics and providing chiroprody services to nursing homes where there is little or no medical supervision of the treatment the chiroprodists provide. We believe it is only logical that chiroprodists be allowed to communicate a diagnosis identifying a disease or disorder of the foot.

Under the existing Chiroprody Act chiroprodists have exercised the right to diagnose. Chiroprodists are trained to diagnose in their clinical and didactic training. Without the power to diagnose, the practice of chiroprody will be restricted to simply those institutions in which a physician is supervising. So I would ask the government to seriously consider this also. We go back to remarks made both by the minister and the parliamentary assistant that the intent of this legislation is to expand the practices in medicare, not to maintain the status quo where only physicians can diagnose.

Mr Wessenger: I would like to oppose this amendment on the basis that chiroprodists in fact do not diagnose, as indicated with respect to the prior amendment made to the previous act: They assess. It is interesting to note under the act, though, that podiatrists can diagnose because they have the extra training which enables them to do that because they do surgery on the foot, which chiroprodists do not do.

Motion negatived.

The Chair: Mr Wessenger moves that paragraph 1 of subsection 5(2) of the bill be struck out and the following substituted:

"1. Communicating a diagnosis identifying a disease or disorder of the foot as the cause of a person's symptoms."

Mr Wessenger: This is a consequential amendment resulting from the amendments to the diagnosis controlled act in subsection 26(2) of Bill 43.

Motion agreed to.

Section 5, as amended, agreed to.

L'article 5, modifié, est adopté.

1600

Section 6 agreed to.

L'article 6 est adopté.

Section/article 7:

The Chair: Mr Wessenger moves that clause 7(1)(a) of the bill be amended by striking out "at least seven and no more than ten" in the first line and substituting "at least six and no more than nine."

Mr Wessenger further moves that clause 7(1)(b) of the bill be amended by striking out "at least four and no more than six" in the first line and substituting "at least five and no more than eight."

Mr J. Wilson: I certainly will not be supporting this amendment on behalf of my caucus because we believe it erodes the principle of self-regulation.

Motion agreed to.

Section 7, as amended, agreed to.

L'article 7, modifié, est adopté.

Section 8 agreed to.

L'article 8 est adopté.

Sections 9 to 15/articles 9 à 15:

The Acting Chair (Mr Brown): Mr Wessenger moves that sections 9 to 15, inclusive, be struck out.

Mr Wessenger: These are no longer required because of the Liberal amendment that was accepted that designated that these matters would be dealt with in regulations as distinct from being in the act.

Motion agreed to.

Sections 9 to 15, inclusive, deleted.

Les articles 9 à 15, inclusivement, sont rayés.

Section 16 agreed to.

L'article 16 est adopté.

Section/article 17:

The Acting Chair: Mr Wessenger moves that subsection 17(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

Mr Wessenger: Again, this is to give title protection outside health care, as we are getting involved in the titles with this act.

Motion agreed to.

Section 17, as amended, agreed to.

L'article 17, modifié, est adopté.

Sections 18 and 19 agreed to.

Les articles 18 et 19 sont adoptés.

Section/article 20:

The Acting Chair: Mr Wessenger moves that section 20 of the bill be amended,

(a) by striking out "college" in the third line and substituting "council";

(b) by striking out "restricting" in the first line of clause (a) and substituting "designating"; and

(c) by striking out clause (c).

Motion agreed to.

Section 20, as amended, agreed to.

L'article 20, modifié, est adopté.

Sections 21 to 23, inclusive, agreed to.

Les articles 21 à 23, inclusivement, sont adoptés.

The Chair: I assume the committee would like to hold down section 24 to be dealt with two weeks from last Monday, on the 21st.

Mr Wessenger: Yes.

The Chair: We will hold that down.

Section 25 agreed to.

L'article 25 est adopté.

Title agreed to.

Le titre est adopté.

The Chair: We will hold the rest now until we complete the bill.

CHIROPRACTIC ACT, 1991

LOI DE 1991 SUR LES CHIROPRACTIENS

The Chair: The clerk is handing out a replacement amendment to section 3. It replaces what is in your package.

Sections 1 and 2 agreed to.

Les articles 1 et 2 sont adoptés.

Section/article 3:

The Chair: Mr Wessenger moves that section 3 of the bill be struck out and the following substituted:

"3. The practice of chiropractic is the assessment of conditions related to the spine, nervous system and joints and the diagnosis, prevention and treatment, primarily by adjustment, of,

"(a) dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous system; and

"(b) dysfunctions or disorders arising from the structures or functions of the joints."

Mr Wessenger: This amendment recognizes that chiropractors are qualified to diagnose and treat dysfunctions and disorders related to the spine and joints.

Mr J. Wilson: I think it is appropriate at this time to commend the government for this new scope-of-practice wording. We will be supporting it, and I withdraw my amendment on the page following concerning the same section.

Motion agreed to.

Section 3, as amended, agreed to.

L'article 3, modifié, est adopté.

Section/article 4:

The Chair: Mr Wessenger moves that paragraph 1 of section 4 of the bill be struck out and the following substituted:

"1. communicating a diagnosis identifying, as the cause of a person's symptoms,

"i. a disorder arising from the structures or functions of the spine and their effects on the nervous system, or

"ii. a disorder arising from the structures or functions of the joints of the extremities."

Mr Wessenger: Again, this amendment authorises chiropractors to communicate a diagnosis of a disorder of the spine or joints of the extremities.

Mr J. Wilson: Again I would like to commend the government for this amendment. It shows that every once in a while it does listen to the groups that appear before this committee. I was wondering up to this point whether there was any sense having the hearings, but you have restored my faith in the fact that you do listen. Second, I will withdraw my amendment dealing with the same section.

Motion agreed to.

1610

The Chair: Mr Wessenger moves that section 4 of the bill be amended by adding the following paragraph:

"3. putting a finger beyond the anal verge for the purpose of manipulating the tailbone."

Motion agreed to.

Section 4, as amended, agreed to.

L'article 4, modifié, est adopté.

Section 5 agreed to.

L'article 5 est adopté.

Section/article 6:

The Chair: Mr Wessenger moves that clause 6(1)(a) of the bill be struck out and the following substituted:

"(a) nine persons who are members elected in the prescribed manner."

Mr Wessenger further moves that clause 6(1)(b) of the bill be amended by striking out "at least four and no more than six" in the first line and substituting "seven."

Mr Wessenger: This amendment gives effect to the government's decision to increase public representation to just under half.

Mr J. Wilson: I will be opposing this government amendment. Committee members will recall that we had introduced an amendment to Bill 43 that would have strengthened the principle of self-regulation in terms of allowing for a 60-40 split between professional and lay members. Consistent with that, I will be voting against this amendment.

Motion agreed to.

Section 6, as amended, agreed to.

L'article 6, modifié, est adopté.

Section 7 agreed to.

L'article 7 est adopté.

Sections 8 to 14/articles 8 à 14:

The Chair: Mr Wessenger moves that sections 8 to 14, inclusive, be struck out.

Mr Wessenger: This is again because of the Liberal amendment which provides that these matters be dealt with by regulation.

Mr Beer: In the spirit of Mr Wilson's earlier comments I would like to commend the government, in each of these bills, for having responded in the way it has, which also shows the way this committee has been able to work co-operatively.

Mr Wessenger: Thank you very much, Mr Beer.

Motion agreed to.

The Chair: I would note the unanimous consent of the deletion of sections 8 to 14, inclusive. All in favour? No dissent.

Sections 8 to 14, inclusive, deleted.

Les articles 8 à 14, inclusivement, sont rayés.

Section 15 agreed to.

L'article 15 est adopté.

Section/article 16:

The Chair: Mr Wessenger moves that subsection 16(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

Motion agreed to.

Section 16, as amended, agreed to.

L'article 16, modifié, est adopté.

Sections 17 to 21, inclusive, agreed to.

Les articles 17 à 21, inclusivement, sont adoptés.

The Chair: I assume the committee would like to stand down discussion on section 22 until October 21, in two weeks?

Mr Wessenger: Yes.

The Chair: That is stood down on section 22.

Section 23 agreed to.

L'article 23 est adopté.

Title agreed to.

Le titre est adopté.

The Chair: The rest we will stand down until we have completed the bill.

A matter of housekeeping on the other two bills deal with today which deleted significant sections: For the record, we have unanimous consent to delete those sections as they related to the other bills. I think they were 8 to 14 inclusive.

Could I have unanimous consent to delete, as per the appropriate sections of the previous two bills? All in favour? No dissent. Unanimous consent is noted.

Mr Owens: Now that we are on to housekeeping items, some are reruns already. I would like to take the opportunity to move that the committee deal with the sexual abuse and patient relations committee issues two weeks from yesterday, October 21 at 3:30 pm.

The Chair: Mr Owens moves that the committee deal with all matters relating to the sexual assault items in all pieces of the legislation before us on Monday, October 21, immediately following question period at approximately 3:30.

Motion agreed to.

The Chair: Having concluded discussion of the three bills, I think it might be appropriate at this time if we had agreement from the committee as to the tabling of amendments and ordering of business for the next time we meet, which will be next Tuesday.

Mr Wessinger: I might suggest we could deal with Bills 47 to 56 next Tuesday. We might not reach them, but those are the ones I would suggest we have on the agenda.

The Chair: The suggestion has been that we deal with Bills 47 to 56. That would mean trying to have amendments tabled by this Friday, if possible, so that we could deal next Tuesday with the package as proposed by Mr Wessinger. Mr Wilson, you wanted to comment?

Mr J. Wilson: I think, in all fairness to people who are watching these committee proceedings and are monitoring them on behalf of their associations, we are going quite quickly and we should not attempt to do such a large chunk next Tuesday. Perhaps it would be more reasonable to decide on doing the next four or five bills. That is as far as I would be willing to go at this time.

Mr Beer: Dare I add a compromise that we just do the next six?

The Chair: It may not be possible to do all six, but if we can at least table the amendments, then I think it would be helpful for anyone who is monitoring the hearings.

Mr Beer: That would take us up to Bill 52 if we did that.

The Chair: Yes, if that is possible.

Mr Owens: I was going to suggest that the province of Ontario has been dealing with this process for close to 11 years. It is not a new process. I am sure your party has had ample time to think about the kind of amendments it would like to put forward. With due respect to your researchers more particularly, I think the amendments should be ready to go, and we need to get this bill done so that the regulations and the interim advisory committee—

The Chair: Mr Owens, with your concurrence, I would like to intervene and remind all members of the committee that amendments can be posed at any time during the process. The fact that we are asking for caucuses to have tabled amendments by this Friday does not mean they cannot be proposed when we actually deal with those bills. Similarly, if at any point during the committee process any member of the committee wishes to ask that a bill be stood down, that is also appropriate at that time. I would just point out to all committee members that we have had a very good process to this point, and hopefully, by working together co-operatively, that can continue.

If Mr Wilson does not feel the Conservatives can have all six available, I think out of courtesy we can—

Mr J. Wilson: I do not think that is the question at all. The question is, going back to Mr Owens's comments, that simply I would take note of the fact that he says the process has gone on for 11 years. Many groups that appeared before this committee told us that this process and the intent of the legislation had changed dramatically over that period of time.

Second, if the government had had, as is tradition around here and as is expected around here from governments that have their shops in order, its amendments to us a month before we got into this process we would not be here today bickering about who is going to bring amendments forward, when and at what time. You are responsible as a government for bringing forward your amendments to us prior to the clause-by-clause of this legislation. So do not be throwing back at us any crap about not having amendments ready.

I was very angry at the beginning of this process, and I have kept quiet to date, at the fact that you guys did not seem to have your act together. I am not willing at this point to agree on anything for next Tuesday. I think we will proceed one bill at a time and see where we get, as I think you have indicated yourself, Madam Chair.

The Chair: Perhaps cooler heads will prevail. If we could try to have amendments available for this Friday for as many bills as members feel they could proceed with, we will reconvene next Tuesday and hopefully in the spirit of co-operation we will be able to proceed.

Mr Beer: I just want to note as well that in terms of the two opposition parties, as we discuss these individual bills with our caucuses, I think we need to be mindful of the time we have for that as well. I think we are moving with some dispatch and some co-operation. Despite the fact we have been at this for eight years, we want to make sure that the final product is thought through. I think next Tuesday we will try to deal with as many as we can. We are going to be finished all of these and if we get up to Bill 50, 51, 52 or whatever, I do not think that matters. We will try to get our amendments in and see if we can do it for those six. But as you yourself said, amendments can be moved at any time and we would want to do that.

The Chair: There has been a great deal of courtesy at the committee to stand down bills or any sections of bills there was further debate and discussion on.

The business for the committee being completed today, I suggest we adjourn at this time and reconvene on Tuesday of next week.

The committee adjourned at 1621.

CONTENTS

Tuesday 8 October 1991

Regulated Health Professions Act, 1991, and companion legislation / Loi de 1991 sur les professions de la santé réglementées et les projets de loi qui l'accompagnent	S-853
Audiology and Speech-Language Pathology Act, 1991 / Loi de 1991 sur les audiologues et les orthophonistes	S-853
Chiropody Act, 1991 / Loi de 1991 sur les podologues	S-855
Chiropractic Act, 1991 / Loi de 1991 sur les chiropraticiens	S-857

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

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Tuesday 15 October 1991

Standing committee on social development

Regulated Health
Professions Act, 1991
and companion legislation

Assemblée législative de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le mardi 15 octobre 1991

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent



Chair: Elinor Caplan
Clerk: Lynn Mellor

Présidente : Elinor Caplan
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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 15 October 1991

The committee met at 1605 in room 151.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

DENTAL HYGIENE ACT, 1991 LOI DE 1991 SUR LES HYGIÉNISTES DENTAIRES

The Chair: We are beginning now with Bill 47, An Act respecting the regulation of the Profession of Dental Hygiene.

Sections 1 and 2 agreed to.
Les articles 1 et 2 sont adoptés.
Section/article 3:

The Chair: Mr Wessenger moves that section 3 of the bill be amended by striking out "on the order of a member of the Royal College of Dental Surgeons of Ontario" in the fourth, fifth and sixth lines.

Mr Wessenger: This removes the reference to doing things on the order of a dentist and it is related to the amendment to section 4 which rephrases the order requirement for performance of authorized acts. It was not logically and necessarily part of the scope statement and the problem is, if it is left in, dental hygienists could potentially be prosecuted under the harm clause if they performed an authorized act without an order. The matter should really only be dealt with, disciplined by the college.

Motion agreed to.
Section 3, as amended, agreed to.
L'article 3, modifié, est adopté.

The Chair: I believe you have an amendment, Mr Beer.

Mr Beer: Yes, our proposed amendment can be withdrawn because of the amendment we just passed. It is similar.
Section/article 4:

The Chair: Mr Wessenger moves that section 4 of the bill be amended by striking out "on the order of a member of the Royal College of Dental Surgeons of Ontario" in the last three lines of paragraphs 1 and 2.

Mr Wessenger: This is related to section 4.1 and makes it clear that a dentist; does not order a hygienist, the dentist orders a procedure.

Motion agreed to.

Section 4, as amended, agreed to.
L'article 4, modifié, est adopté.

The Chair: Mr Wessenger moves that the bill be amended by adding the following section:

"4.1(1) A member shall not perform a procedure under the authority of section 4 unless the procedure is ordered by a member of the Royal College of Dental Surgeons of Ontario.

"(2) In addition to the grounds set out in subsection 49(1) of the health professions procedural code, a panel of the discipline committees shall find that a member has committed an act of professional misconduct if the member contravenes subsection (1)."

Mr Wessenger: I think we have already covered this aspect to indicate that it is a breach if a hygienist performs a procedure without an order.

Motion agreed to.
Section 5 agreed to.
L'article 5 est adopté.

Section/article 6:

The Chair: Mr Wessenger moves that subsection 6(1) of the bill be amended,

(a) by striking out: "at least seven and no more than ten" in the first line of clause (a) and substituting "at least nine and no more than twelve";

(b) by striking out "at least four and no more than six" in the first line of clause (b) and substituting "at least eight and no more than eleven"; and

(c) by striking out "one or two" in the first line of clause (c) and substituting "two."

Mr Wessenger: This is to make sure that the council composition is just under half members.

Mr J. Wilson: We will be opposing this amendment as we believe it violates, to some degree, the principle of self-regulation.

Mr Hope: I believe we will be supporting this because it does allow the majority. It still holds 50 plus 1, which gives the right for self-government.

The Chair: Further debate? Shall the amendment carry? All those in favour of the amendment? Any opposed?

Motion agreed to.
Section 6, as amended, agreed to.
L'article 6, modifié, est adopté.

Section 7 agreed to.
L'article 7 est adopté.

Section/article 8:

The Chair: Shall section 8 carry? I know you have to vote against.

Mr Wessenger: We have to vote against.

The Chair: I understand the intention. The clerk advises me the correct wording is, shall section 8 stand as part of the bill? All those in favour? Those opposed?

Section 8 deleted.
L'article 8 est rayé.

The Chair: Just for the information of all committee members, a motion to delete is not in order so we have to ask if the section shall stand as part of the bill, given the changes to the previous section, rather than deleting sections 8 to 14 as we did in previous bills. This is a more correct way of dealing with it.

Sections 9 to 14, inclusive, deleted.
Les articles 9 à 14, inclusivement, sont rayés.

Mr Hope: A point of clarification, Madam Chair, on the way we did the other bills: Are they still valid under the proper process?

The Chair: If you will recall, Mr Hope, I requested unanimous consent from the committee to deal with the other bills, and according to the clerk that makes it valid because there was unanimous consent. I have been advised that according to parliamentary procedures the new wording we have used today would not require unanimous consent and is therefore a better way of proceeding.

Section/article 15:

The Chair: Mr Wessenger moves that subsection 15(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

Mr Wessenger: The purpose of this, of course, is in accordance with all the other bills to take out the aspect of title protection being only in the course of providing health care.

Motion agreed to.
Section 15, as amended, agreed to.
L'article 15, modifié, est adopté.
Sections 16 and 17 agreed to.
Les articles 16 et 17 sont adoptés.

Section/article 18:

The Chair: Mr Wessenger moves that section 18 of the bill be amended by striking out "college" in the third line and substituting "council" and by striking out clause (c).

Motion agreed to.

The Chair: Mr Wessenger moves that clause 18(b) of the bill be amended by striking out "number" in the first line.

Mr Wessenger: This is merely a housekeeping change.
Motion agreed to.

Section 18, as amended, agreed to.
L'article 18, modifié, est adopté.
Sections 19 to 21, inclusive, agreed to.
Les articles 19 à 21, inclusivement, sont adoptés.

Section/article 22:

The Chair: Mr Wessenger moves that section 22 of the bill be amended by adding the following subsection:

"(4) Despite subsection (1), section 81.1 of the health professions procedural code, as it applies in respect of this act, does not come into force until one year after this act comes into force."

And that this should be stood down until October 21.

On the motion to stand down, all in favour? Any opposed?

Motion agreed to.
Section 22 deferred.
L'article 22 est différé.
Section 23 agreed to.
L'article 23 est adopté.

Title agreed to.
Le titre est adopté.

The Chair: We have to hold the rest until we have dealt with section 22, which has been stood down.

DENTAL TECHNOLOGY ACT, 1991

LOI DE 1991

SUR LES TECHNICIENS DENTAIRES

Section/article 1:

The Chair: Mr Wessenger moves that the French version of section 1 of the bill be amended,

(a) by striking out "techniciens" in the definition of "ordre" and substituting "technologues"; and
(b) by striking out "technicien" in the definition of "profession" and substituting "technologue."

Motion agreed to.
Section 1, as amended, agreed to.
L'article 1, modifié, est adopté.

Section/article 2:

The Chair: Mr Wessenger moves that the French version of subsection 2(2) of the bill be amended,

(a) by striking out "techniciens" in the definition of "ordre" and substituting "technologues"; and
(b) by striking out "technicien" in the definition of "profession" and substituting "technologue."

Motion agreed to.
Section 2, as amended, agreed to.
L'article 2, modifié, est adopté.

Section/article 3:

The Chair: Mr Wessenger moves that section 3 of the bill be amended by striking out "on the order of a person authorized under a health profession act as defined in the Regulated Health Professions Act, 1991 to fit or dispense the devices" in the last four lines.

Do you have another amendment as well to section 3?

Mr Wessenger: No, I believe the other one is being withdrawn.

The Chair: Okay. Is there any discussion on this amendment?

Motion agreed to.
Section 3, as amended, agreed to.
L'article 3, modifié, est adopté.

Section/article 4:

The Chair: Mr Wessenger moves that the English version of section 4 of the bill be amended by striking out "techniciens" in the fourth line and substituting "technologues."

And he further moves that the French version of section 4 of the bill be amended by striking out "techniciens" in the third line and substituting "technologues."

Motion agreed to.

Section 4, as amended, agreed to.

L'article 4, modifié, est adopté.

1620

Section/article 5:

The Chair: Mr Wessenger moves that clause 5(1)(a) of the bill be struck out and the following substituted:

"(a) seven persons who are members elected in the prescribed manner; and"

And he further moves that clause 5(1)(b) of the bill be amended by striking out "at least four and no more than six" in the first line and substituting "six."

Mr J. Wilson: I will be voting against this section because we do believe that the government's proposal to have the number of lay members on council to just under 50% does erode the principle of self-regulation.

The Chair: Further discussion on the amendment?

Mr J. Wilson: Mr Hope has his usual line.

The Chair: Did you want to repeat that again?

Mr Hope: No—my usual line.

Motion agreed to.

Section 5, as amended, agreed to.

L'article 5, modifié, est adopté.

Section 6 agreed to.

L'article 6 est adopté.

Section/article 7:

The Chair: My wording is going to be a little different in light of the amendment to section 5. Shall section 7 stand as part of the bill? All those in favour? Any opposed?

Section 7 deleted.

L'article 7 est rayé.

Sections 8 to 13, inclusive, deleted.

Les articles 8 à 13, inclusivement, sont rayés.

Section/article 14:

The Chair: Mr Wessenger moves that subsection 14(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

Mr Wessenger: Again, this amendment is to carry out the title provision beyond the provision of health care.

The Chair: All those in favour? Any opposed?

Motion agreed to.

The Chair: Mr Wessenger moves that the French version of subsection 14(1) of the bill be amended by striking out "technicien" in the second line and substituting "technologue."

And he further moves that the French version of subsection 14(3) of the bill be amended by striking out "technicien" in the fourth line and substituting "technologue."

Motion agreed to.

Section 14, as amended, agreed to.

L'article 14, modifié, est adopté.

Sections 15 and 16 agreed to.

Les articles 15 et 16 sont adoptés.

Section/article 17:

The Chair: Shall section 17 stand as part of the bill? All those in favour? Any opposed?

Section 17 deleted.

L'article 17 est rayé.

Sections 18 to 20, inclusive, agreed to.

Les articles 18 à 20, inclusivement, sont adoptés.

Section/article 21:

The Chair: Mr Wessenger moves that section 21 of the bill be amended by adding the following subsection:

"(4) Despite subsection (1), section 81.1 of the health professions procedural code, as it applies in respect of this act, does not come into force until one year after this act comes into force."

And that this be stood down until October 21.

The Chair: Motion to stand down. All those in favour?

Motion agreed to.

Section/article 22:

The Chair: Mr Wessenger moves that the French version of section 22 of the bill be amended by striking out "techniciens" and substituting "technologues."

Motion agreed to.

Section 22, as amended, agreed to.

L'article 22, modifié, est adopté.

Title/title:

The Chair: Mr Wessenger moves that the French version of the long title of the bill be amended by striking out "technicien" and substituting "technologue."

Motion agreed to.

The Chair: Shall the title, as amended, carry? All those in favour? Any opposed?

Title, as amended, agreed to.

Le titre, modifié, est adopté.

The Chair: That is as far as we can go today on Bill 48. Section 21 has been stood down and we will complete the bill when we complete that section.

DENTISTRY ACT, 1991

LOI DE 1991 SUR LES DENTISTES

The Chair: Are we ready to proceed? Did I have a request for a recess, Mr Hope?

Mr Hope: My arm is getting a little sore.

Sections 1 to 3, inclusive, agreed to.

Les articles 1 à 3, inclusivement, sont adoptés.

Section/article 4:

The Chair: We have several amendments to section 4. I am going to ask that all the amendments be placed first, since they seem to be very similar.

Mr Wessenger moves that paragraph 1 of section 4 of the bill be struck out and the following substituted:

"1. Communicating a diagnosis identifying a disease or disorder of the oral-facial complex as the cause of a person's symptoms."

And he further moves that section 4 of the bill be amended by adding the following paragraph:

"5.1 Applying or ordering the application of a prescribed form of energy."

The Chair: Do you want to speak to your amendment or allow the others to comment first? We have other amendments that are similar.

Mr Wessenger: I wonder whether they are going to proceed with those.

Mr Beer: I would like to withdraw our amendment as it is the same as the government amendment.

Mr J. Wilson: I too would withdraw the PC amendment. It is very similar to the government amendment.

The Chair: I think we can assume this vote is going to be unanimous.

Mr Wessenger: This amendment removes the word "dysfunction" from the diagnosis authorized act in accordance with the act in Bill 43. It also authorizes dentists to apply or order the application of a prescribed form of energy which the dentists asked for. We felt it should be in the bill.

Motion agreed to.

The Chair: Mr Wessenger moves that paragraph 7 of section 4 of the bill be amended by inserting after "orthodontic" in the second line "or periodontal."

Motion agreed to.

Section 4, as amended, agreed to.

L'article 4, modifié, est adopté.

Section 5 agreed to.

L'article 5 est adopté.

1630

Section/article 6:

The Chair: Mr Wessenger moves that clause 6(1)(a) of the bill be amended by striking out "at least ten and no more than fourteen" in the first line and substituting "at least ten and no more than twelve."

And he further moves that clause 6(1)(b) of the bill be amended by striking out "at least six and no more than eight" in the first line and substituting "at least nine and no more than eleven."

And he further moves that clause 6(1)(c) of the bill be struck out and the following substituted:

"(c) two persons selected in the prescribed manner from among members who are members of a faculty of dentistry of a university in Ontario."

Mr Wessenger: This again changes the council composition to make public members just under half.

Mr J. Wilson: I will be voting against the government's amendment. We believe the amendment erodes the principle of self-government and we had put forward an amendment earlier which would have given a 60-40 split in terms of professional members versus lay members on the council.

Mr Hope: I will be supporting the amendment as put forward. I think it adds light with more of the general public being actively involved and understanding what this legislation is intended to do. I still believe it gives the right to self-governance.

The Chair: Shall the amendment carry? All those in favour? Those opposed?

Motion agreed to.

Section 6, as amended, agreed to.

L'article 6, modifié, est adopté.

Section 7 agreed to.

L'article 7 est adopté.

Section/article 8:

The Chair: Shall section 8 stand as part of the bill? All those in favour? Those opposed?

Section 8 deleted.

L'article 8 est rayé.

Sections 9 to 14, inclusive, deleted.

Les articles 9 à 14, inclusivement, sont rayés.

Section 15 agreed to.

L'article 15 est adopté.

Section/article 16:

The Chair: Mr Wessenger moves that subsection 16(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

We have heard discussion on this before. All those in favour? Any opposed?

Motion agreed to.

Section 16, as amended, agreed to.

L'article 16, modifié, est adopté.

Section/article 17:

The Chair: Shall section 17 stand as part of the bill? Those in favour? Those opposed?

Section 17 deleted.

L'article 17 est rayé.

Sections 18 and 19 agreed to.

Les articles 18 et 19 sont adoptés.

Section/article 20:

The Chair: Mr Wessenger moves that section 20 of the bill be amended by striking out "college" in the third line and substituting "council" and by striking out clause (c).

Motion agreed to.

Section 20, as amended, agreed to.

L'article 20, modifié, est adopté.

Section 21 agreed to.

L'article 21 est adopté.

Section/article 22:

The Chair: Mr Wessenger moves that the French version of subsection 22(1) of the bill be amended by inserting after "est" in the first line "le conseil de."

Motion agreed to.

Section 22, as amended, agreed to.

L'article 22, modifié, est adopté.

Section 23 agreed to.

L'article 23 est adopté.

Section/article 24:

The Chair: Mr Wessenger moves that section 24 of the bill be amended by adding the following subsection:

“(4) Despite subsection (1), section 81.1 of the health professions procedural code, as it applies in respect of this act, does not come into force until one year after this act comes into force.”

And that this be stood down until October 21.

The Chair: There is a motion to stand down. All those in favour?

Motion agreed to.

L'article 25 est adopté.

Title agreed to.

Le titre est adopté.

The Chair: We have gone as far as we can on Bill 49 and hope to complete that on October 21, if possible.

DENTURISM ACT, 1991

LOI DE 1991 SUR LES DENTUROLOGUES

Section/article 1:

The Chair: Mr Wessenger moves that the French version of section 1 of the bill be amended,

(a) by striking out “denturologues” in the definition of “ordre” and substituting “denturologistes”; and

(b) by striking out “denturologue” in the definition of “profession” and substituting “denturologiste.”

Motion agreed to.

Section 1, as amended, agreed to.

L'article 1, modifié, est adopté.

Section/article 2:

The Chair: Mr Wessenger moves that the French version of subsection 2(2) of the bill be amended,

(a) by striking out “denturologues” in the definition of “ordre” and substituting “denturologistes”; and

(b) by striking out “denturologue” in the definition of “profession” and substituting “denturologiste.”

Motion agreed to.

Section 2, as amended, agreed to.

L'article 2, modifié, est adopté.

Section 3 agreed to.

L'article 3 est adopté.

Section/article 4:

The Chair: Mr J. Wilson moves that section 4 of the bill be amended by adding the following subsection:

“(2) Despite subsection (1), a member is not authorized to fit or dispense partial dentures except on the order or prescription of a member of the Royal College of Dental Surgeons of Ontario.”

Mr J. Wilson: I ask support from committee members on this amendment. Our concern is one of public protection, in the sense that we are very worried that people will now go to their denturists for primary dental care, that the first stop they will make is at the dentist's office rather than have a complete oral examination by a dentist. We believe and argue that those seeking dentures—it certainly was the contention of many of the dental professionals who appeared before this committee—should be subject to a full examination by a dentist, whether they are going for either full or partial dentures.

There has been some evidence of harm, I gather, by denturists performing partial dentures illegally in the past. That has been disputed. All members of the committee are aware of the long-standing debate in this area. In my remarks here, we are clearly taking the side of the evidence put before us by the dentists in this area at this time. Again, we believe the protection of the public should be of paramount interest here.

Mr Beer: We will not be supporting the amendment put forward by my colleague. I think we all accept that this was one of the more difficult issues. Frankly, we found the evidence put forward on this by Mr Schwartz, the commissioner, to be compelling. We believe the new College of Denturists of Ontario will be able to apply rules and procedures which will ensure that the public is protected. I think we all recognize that whether it is dentists or denturists or any profession, no single piece of legislation can ultimately ensure that nothing will go wrong at some point in time. In our view, in the light of the principles by which we are trying to protect the public and also provide for a broader range of service, the denturists are at a point in the development of their own profession where this can stand as originally put forward in the legislation. We will support the legislation as written and not support this amendment.

1640

Mr Wessenger: We will also be opposing this amendment, based on some of the reasons given by Mr Beer with respect to the testimony of Mr Schwartz, who indicated there was no evidence of any harm being done. Also, I think there is a certain illogical aspect to requiring a dentist's approval for a partial plate when there is not even a requirement for a full plate. I think members of the public clearly understand when they go to a denturist that they are not going to have their mouth looked at for determining its health. If that is their concern, they will go to a dentist. I do not think there is any harm to the public in this area. It would be an additional unnecessary expense to the public with no benefit.

Mr Owens: I have some sympathy for the amendment put forward by Mr Wilson. What I cannot wrap my mind around is the issue of access and the difficulties that may accrue by keeping dentists as the gatekeepers to denturists. I have spoken with members of both associations and in my mind I think we should dispense some free advice to both colleges. As the colleges are set up and as they mature in their relationship, they should begin to work in a collegial manner rather than the combative manner we have seen through the deputations and testimony, because I think there is an issue to be made with respect to good oral care. But I think that will be set forward in a co-operative manner rather than in a legislative manner.

Mr J. Wilson: Just in final argument, if you as legislators do not accept that there has been some evidence of harm from denturists constructing partial dentures in the past, surely you would accept the argument that there is great potential for harm in the future, if you give them this controlled act. I think we should err, if we are erring, on the side of public protection. The parliamentary assistant mentioned extra expense in requiring patients to go to a

dentist before going to a denturist. The logic there is inconsistent with the same logic we applied to audiologists and speech-language pathologists, where we require patients to go to audiologists and speech-language pathologists as the primary point of entry for hearing aids. We have passed that bill so far in our hearings. We did that because we wanted to ensure the public was protected, as I understand it.

The parliamentary assistant mentioned that there was something illogical about denturists being able to perform full dentures but not partials. I think the case was made very clear by dentists that they have the training and medical background required and that more of a medical background is required before one actually starts tampering with teeth that remain in the mouth and adding partial dentures or affixing partial dentures to those teeth. There is a difference between a case where there are no teeth and a case where there are teeth. That is the crux of the argument we are having here right now.

Mr Owens: Just as a quick comment around cost, I think the issue the parliamentary assistant may have been trying to raise with respect to cost is that not all people have dental plans and that there are people who fall between the cracks. As I understand it from conversations with constituents, some of the municipalities are getting out of the business of providing dental care through general welfare assistance or family benefits, so you are looking at people who are going to fall between the cracks. How can we get those people into good dental care? I know there are professionals out there who practise social dentistry and who are willing to give patients a break, but how do you encourage that kind of activity? Do you legislate it or do you try and use moral suasion on people and hope they will give them a break?

Mr J. Wilson: If we are sending people there as the primary entry and we are allowing them to get partial dentures, a concern that was expressed by many professionals was that they may not recognize certain diseases, such as the early stages of AIDS, gum diseases and other diseases of the mouth. Cancer, for instance, was brought to our attention. We may have to increase the training for denturists, which I see eventually driving up the cost of that service because they are going to have to have a more complete medical background to be able to properly look after those people who will now rely on them as their primary entry to dental services.

Ms Haack: In my capacity as an MPP, I have had the opportunity to meet with constituents whom I asked to write to this committee because they were very concerned about dentistry practised in St Catharines-Brock. They felt very positively towards their denturist and had some rather negative feelings towards their dentist. The reality of practice out there, as well as what this act would set out to do, is that dentists have the right, the opportunity, to carry on the large field of dental care and denturists are obviously restricted in what they can do around the providing of plates, partial or complete, as per this legislation. From what I have seen out there, this is something the public feels very positively towards and I must concur with that wish.

Mr Beer: I would like to return us all to a couple of other points we are trying to meet with the legislation. One is that we are dealing with two professional groups here. I think that in the light of what Mr Owens said earlier, in a number of areas we are going to have professional groups involved in health care coming together and working together.

It seems to me that the new councils we are creating, and this is one good example, will be leaning over backwards to ensure that the fundamental procedures they set up are going to really focus on protecting the public. I think we can rely on the judgement of both those groups to do that. In many communities—I think of my own—the relationship between dentists and denturists is a very positive one. I would see that in the normal course, as this works its way out, that would continue to be the case.

The final point I would make covers a great many of the things we are doing here. The consumer also has a responsibility. I think we can go to a certain point in protecting the public, but fundamentally and ultimately in many of these areas we are going to have to be looking at improved education to the consumer about health care services. I think each of us and our friends in our own communities has a responsibility to do that as well. Again, it is a balance we are trying to find and I think that is what we have found in terms of the original legislation.

1650

Mr J. Wilson: I have just some final remarks, and I promise they are final, Madam Chair, because I believe most members by their remarks have decided how they are going to vote at this stage. I would say in response to Ms Haack's comments that a couple of denturists appeared before our committee who certainly would have no problem with our amendment. They had been working, as Mr Beer said, co-operatively for years in the community with the dentists. The dentist at one end of the building does the full examination and writes the prescription or order for fitting of dentures, and the patients then go down and have the technical work done by the denturist. I see that as a good system, a co-operative system, and that was the intent of my amendment.

Mr Wessinger: I think there is some indication that the dentists and the denturists will be able to work well together. Certainly there was evidence of that, as you said, Mr Wilson, in some of the appearances before the committee. But I think we should also remember that each profession has its own quality assurance programs and its own competency standards, so these will be developed by the denturists. I have confidence that those standards, as developed, will give good guidance to have good-quality care with respect to the provision of partial denture plates. I am sure part of that is that it would be a policy of the denturist to ensure that anyone who might have a health problem would be referred to the proper person, whether that would be a medical doctor or a dentist. So I am confident that will be worked out through the quality assurance program for the denturists.

The Chair: All those in favour of the amendment? Those opposed?

Motion negatived.

Section 4 agreed to.
L'article 4 est adopté.

Section/article 5:

The Chair: Mr Wessenger moves that the English version of section 5 of the bill be amended by striking out "denturologues" in the fourth line and substituting "denturologistes."

And he further moves that the French version of section 5 of the bill be amended by striking out "denturologues" in the third line and substituting "denturologistes."

Motion agreed to.

Section 5, as amended, agreed to.
L'article 5, modifié, est adopté.

Section/article 6:

The Chair: Mr Wessenger moves that clause 6(1)(a) of the bill be amended by striking out "at least eight and no more than ten" in the first line and substituting "at least seven and no more than eight."

And he further moves that clause 6(1)(b) of the bill be amended by striking out "four or five" in the first line and substituting "at least five and no more than seven."

Ms Haeck: I just wanted to get ahead of Mr Wilson. The torch has been passed from Mr Hope to myself. We strongly feel that this amendment supports the concept of public involvement and definitely gives the college self-governing status.

The Chair: You are not going to disappoint Ms Haeck, are you, Mr Wilson?

Mr J. Wilson: I was going to say, "I fooled you," but none the less I guess my comments are on the record from previous such motions put forward by the government. We will be opposing this, not because we do not believe the public is an integral part of the system; we just also believe you have to have a little more trust in the self-regulating principle.

The Chair: Shall the amendment carry? All those in favour? Those opposed?

Motion agreed to.

Section 6, as amended, agreed to.
L'article 6, modifié, est adopté.

Section 7 agreed to.
L'article 7 est adopté.

Section/article 8:

The Chair: Shall section 8 stand as part of the bill? All those in favour? Those opposed?

Section 8 deleted.
L'article 8 est rayé.

Sections 9 to 14, inclusive, deleted.
Les articles 9 à 14, inclusivement, sont rayés.

Section/article 15:

The Chair: Mr Wessenger moves that subsection 15(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

Mr J. Wilson: I would just like to commend the government on bringing forward this amendment for each of the bills before us.

The Chair: Any further debate?

Mr J. Wilson: I thought, Madam Chair, I should say something positive for a change. This is the one opportunity I have to do that.

The Chair: Duly noted.

Mr Owens: Put that in a press release.

Mr J. Wilson: Put that in your press release.

Motion agreed to.

The Chair: Mr Wessenger moves that the French version of subsection 15(1) of the bill be amended by striking out "denturologue" in the second line and substituting "denturologiste."

And he further moves that the French version of subsection 15(3) of the bill be amended by striking out "denturologue" in the fourth line and substituting "denturologiste."

Motion agreed to.

Section 15, as amended, agreed to.
L'article 15, modifié, est adopté.

Sections 16 and 17 agreed to.
Les articles 16 et 17 sont adoptés.

Section/article 18:

The Chair: Shall section 18 stand as part of the bill? All those in favour? Those opposed?

Section 18 deleted.
L'article 18 est rayé.

Sections 19 to 21, inclusive, agreed to.
Les articles 19 à 21, inclusivement, sont adoptés.

Section/article 22:

The Chair: Mr Wessenger moves that section 22 of the bill be amended by adding the following subsection:

"(4) Despite subsection (1), section 81.1 of the health professions procedural code, as it applies in respect of this act, does not come into force until one year after this act comes into force."

Mr Wessenger: I would ask to stand this down until October 21.

The Chair: Stand this down until October 21.

Section/article 23:

The Chair: Mr Wessenger moves that the French version of section 23 of the bill be amended by striking out "denturologues" in the second line and substituting "denturologistes."

Motion agreed to.

Section 23, as amended, agreed to.
L'article 23, modifié, est adopté.

Title/titre:

The Chair: Mr Wessenger moves that the French version of the long title of the bill be amended by striking out "denturologue" and substituting "denturologiste."

Motion agreed to.

Title, as amended, agreed to.
Le titre, modifié, est adopté.

DIETETICS ACT, 1991
LOI DE 1991 SUR LES DIÉTÉTISTES

Sections 1 to 4, inclusive, agreed to.
Les articles 1 à 4, inclusivement, sont adoptés.
Section/article 5:

The Chair: Mr Wessenger moves that clause 5(1)(a) of the bill be amended by striking out "at least eight and no more than twelve" in the first line and substituting "at least six and no more than nine."

And he further moves that clause 5(1)(b) of the bill be amended by striking out "at least four and no more than six" in the first line and substituting "at least five and no more than eight."

The Chair: All those in favour? All those opposed?
Motion agreed to.

Section 5, as amended, agreed to.
L'article 5, modifié, est adopté.

Section 6 agreed to.
L'article 6 est adopté.

Section/article 7:

The Chair: Shall section 7 stand as part of the bill?
All those in favour? All those opposed?

Section 7 deleted.
L'articles 7 est rayé.

Sections 8 to 13, inclusive, deleted.
Les articles 8 à 13, inclusivement, sont rayés.

The Chair: Mr Wessenger moves that subsection 14(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

Mr J. Wilson: Members will note that on the next page my amendment to this subsection goes a little further in extending further title protection. I certainly would urge members to vote in favour of the government's amendment, which would drop the last half-sentence of my amendment, and then vote for the PC amendment following.

Motion agreed to.

The Chair: Mr J. Wilson moves that the first part of subsection 14(1) of the bill be struck out and the following substituted:

"(1) No person other than a member shall use the title 'dietitian' or 'dietitian nutritionist', a variation or abbreviation or an equivalent in another language."

Mr Wessenger: I would speak in opposition to this motion, because the title "dietitian nutritionist" is not in common use and restricting the word "nutritionist" would interfere with nutritionists who are not members of the college. I think the public would also be confused by the fact that you would have both the titles "dietitian" and "dietitian nutritionist."

Mr Beer: We would not support this particular amendment. We believe the title "dietitian" would be sufficient.

The Chair: Is there any further discussion of the amendment? All those in favour? Those opposed?

Motion negatived.

Section 14, as amended, agreed to.
L'article 14, modifié, est adopté.

Sections 15 and 16 agreed to.
Les articles 15 et 16 sont adoptés.

Section/article 17:

The Chair: Shall section 17 stand as part of the bill?
All those in favour? Any opposed?

Section 17 deleted.
L'article 17 est rayé.

Sections 18 and 19 agreed to.
Les articles 18 et 19 sont adoptés.

Section/article 20:

The Chair: Mr Wessenger moves that section 20 of the bill be amended by adding the following subsection:

"(4) Despite subsection (1), section 81.1 of the Health Professions Procedural Code, as it applies in respect of this act, does not come into force until one year after this act comes into force."

Mr Wessenger: I ask that this be stood down until October 21.

The Chair: Motion to stand down. We will do that.

Section 21 agreed to.
L'article 21 est adopté.

Title agreed to.
Le titre est adopté.

The Chair: I have had a request for a five-minute recess, at which time we will commence on Bill 52.

The committee recessed at 1705.

1711

The Chair: The standing committee on social development is now in session. Are we ready to proceed? You would be a welcome addition to the committee.

Mr J. Wilson: I am a little worried about the colour she is wearing.

The Chair: That did not prompt my comment at all, Mr Wilson. You know how impartial the Chair is on these matters. Do you think we can proceed without Mr Hope?

Mr J. Wilson: Yes, he is hopeless anyway.

The Chair: Now, Mr Wilson, Hansard will not record that.

Mr J. Wilson: I do not care whether they do or not.

The Chair: Are you ready to proceed?

Mr Owens: Let me count my votes here.

MASSAGE THERAPY ACT, 1991
LOI DE 1991 SUR LES MASSOTHÉRAPEUTES

The Chair: We are dealing now with Bill 52, An Act respecting the regulation of the Profession of Massage Therapy.

Sections 1 and 2 agreed to.
Les articles 1 et 2 sont adoptés.

Section/article 3:

The Chair: Mr Wilson moves that section 3 be struck out and the following substituted:

"(3) The practice of massage therapy is the assessment of the soft tissue and joints of the body and the treatment and prevention of physical dysfunction and pain of the soft tissues and joints to develop, maintain, rehabilitate or augment physical function, or to avoid or relieve pain, by manipulation of the soft tissues and mobilization of the joints."

Mr J. Wilson: The purpose of the amendment is to clarify what it is that massage therapists actually do, in particular with respect to their role as opposed to the role of a chiropractor. We believe that the scope of practice as outlined in the PC amendment much more clearly reflects the function and scope of practice of a massage therapist and would ask members to support the amendment.

Mr Wessinger: I would like to oppose the amendment. I think the language is quite clear with respect to manipulation, and I do not know exactly what the word "mobilization" means. In my opinion the massage therapists do in fact manipulate joints in their scope of practice, and that should be the language that should be used, not another word which is less clear.

Mr Beer: I have had, and I think we have had, difficulty in understanding this amendment in the context of what is in the proposed bill, and therefore would prefer to support section 3 as it now stands. There may well be a number of issues such as this where perhaps we want to come back to the role of the advisory council. If there is some doubt as to what certain things mean, in trying to find the essential difference in the two and with the word "manipulation" in both, I do not see that.

Given what we have gone through and in the discussions with the various groups, in our judgement we should go with what is in the present bill but perhaps here, as in a number of other places, ask the advisory council to work together with the councils on massage therapy and chiropractic if it appears down the road that we need some clearer wording, or if there is some confusion to try to sort that out. At this point in time we are not persuaded by my colleague's proposed amendment.

Mr Owens: I would like to agree wholeheartedly with Mr Beer that with the word "manipulation" appearing in two other acts, that is, the chiropractors' and the osteopaths', one would look for some guidance from the advisory council on manipulation within the scopes of practice. The other thing is that I was under the understanding that these two groups had perhaps worked out their concerns with each other, but I guess that is not the case. I would encourage these groups, as Mr Beer has done, to sort out the differences around the term "manipulation" through the interim advisory committee and their colleges.

Mr J. Wilson: Contrary to what the parliamentary assistant has stated, it is certainly my understanding that chiropractors manipulate joints and that massage therapists manipulate soft tissues and mobilize joints. The terminology is extremely important to the professions. I suspect that the advisory council will never really get around to dealing with this matter and I think legislators have a responsibility to

ensure that the wording is as clear as possible before it leaves this committee and is sent to the House for final approval.

The Chair: Further discussion on the amendment? All those in favour? Those opposed?

Motion negatived.

Section 3 agreed to.

L'article 3 est adopté.

Section 4 agreed to.

L'article 4 est adopté.

Section/article 5:

The Chair: Mr Wessinger moves that clause 5(1)(a) of the bill be amended by striking out "at least seven and no more than eight" in the first line and substituting "at least six and no more than seven."

And he further moves that clause 5(1)(b) of the bill be amended by striking out "four" in the first line and substituting "five."

The Chair: To the amendment, all those in favour? Any opposed?

Motion agreed to.

Section 5, as amended, agreed to.

L'article 5, modifié, est adopté.

Section 6 agreed to.

L'article 6 est adopté.

Section/article 7:

The Chair: Shall section 7 stand as part of the bill? All those in favour? Those opposed?

Section 7 deleted.

L'article 7 est rayé.

Sections 8 to 13, inclusive, deleted.

Les articles 8 à 13, inclusivement, sont rayés.

The Chair: Mr Wessinger moves that subsection 14(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

Motion agreed to.

Section 14, as amended, agreed to.

L'article 14, modifié, est adopté.

Sections 15 and 16 agreed to.

Les articles 15 et 16 sont adoptés.

Section/article 17:

The Chair: Shall section 17 stand as part of the bill? Those in favour? Those opposed?

Section 17 deleted.

L'article 17 est rayé.

Sections 18 to 20, inclusive, agreed to.

Les articles 18 à 20, inclusivement, sont adoptés.

Section/article 21:

The Chair: Mr Wessinger moves that section 21 of the bill be amended by adding the following subsection:

(4) Despite subsection (1), sections 81.1 of the health professions procedural code, as it applies in respect of this act, does not come into force until one year after this act comes into force.

Mr Wessenger: I ask to stand this down until October 21.

The Chair: Stood down until October 21.

Section 22 agreed to.

L'article 22 est adopté.

Title agreed to.

Le titre est adopté.

The Chair: I believe we have had an agreement to go as far as Bill 52 today, unless there is a desire to do Bill 53.

Interjection.

The Chair: We are not ready? I would request that any amendments on the next set of bills be tabled with the clerk by Thursday, if that is possible. The clerk has informed me that she is going to be involved with the consti-

tutional conference and will not be available to receive the amendments on Friday.

As we will be dealing next Monday with many of those items that have been stood down, I doubt we will get through very many more of the bills on that day. Has there been an agreement among the whips as to how far we should attempt to proceed next week?

Mr J. Wilson: There has been no agreement to date, but I think it would be reasonable to expect, since Monday will be taken up with other arguments, that we could probably proceed on Tuesday with the next four bills.

The Chair: Agreed? Agreed. We will have the amendments on the next four bills to the clerk from the caucuses by Thursday.

The committee adjourned at 1722.

CONTENTS

Tuesday 15 October 1991

Regulated Health Professions Act, 1991, and companion legislation / Loi de 1991 sur les professions de la santé réglementées et les projets de loi qui l'accompagnent	S-861
Dental Hygiene Act, 1991 / Loi de 1991 sur les hygiénistes dentaires	S-861
Dental Technology Act, 1991 / Loi de 1991 sur les techniciens dentaires	S-862
Dentistry Act, 1991 / Loi de 1991 sur les dentistes	S-863
Denturism Act, 1991 / Loi de 1991 sur les denturologues	S-865
Dietetics Act, 1991 / Loi de 1991 sur les diététistes	S-868
Massage Therapy Act, 1991 / Loi de 1991 sur les massothérapeutes	S-868

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

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First Session, 35th Parliament

Official Report of Debates (Hansard)

Monday 21 October 1991

Standing committee on social development

Regulated Health
Professions Act, 1991
and companion legislation

Assemblée législative de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le lundi 21 octobre 1991

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent



Chair: Elinor Caplan
Clerk: Lynn Mellor

Présidente : Elinor Caplan
Greffière : Lynn Mellor

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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 21 October 1991

The committee met at 1535 in room 151.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES

ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Suite de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

The Chair: The standing committee on social development is now in session. We have agreed that today we will deal with Bill 43, with all the issues and clauses as they relate to the sexual assault recommendations, as well as section 81.1 of schedule 2 and all other related sections. Then, time permitting, we can move on to the other bills. I believe we are at Bill 55.

The parliamentary assistant has requested an opportunity to address the committee at this time.

Mr Wessenger: Before beginning clause-by-clause review of provisions relating to sexual abuse of patients, I would like to make some general comments. We are firmly committed to taking the necessary legislative action to deal with the problem of sexual abuse in a comprehensive manner. As we have said before, we are committed to a policy of zero tolerance of sexual abuse in health care.

The committee has already passed an amendment to section 3 of the Regulated Health Professions Act which adds to the minister's duties the duty of ensuring that individuals are treated with sensitivity and respect in their dealings with health professionals, the colleges and the health professions board.

The committee has also passed an amendment to section 3 of the procedural code adding to the objects of colleges the object of developing, establishing and maintaining programs to assist individuals to exercise their rights under the code and the RHPA.

We are proposing today a set of further amendments to require every college to establish a patient relations program. A new committee, the patient relations committee, would be created to advise the college council on the program. The patient relations program must include measures for preventing professional misconduct of a sexual nature. The Health Professions Regulatory Advisory Council would have in its mandate the duty to advise the minister on the colleges' patient relations programs.

This is not all. The minister will shortly be signing a letter addressed to the head of each regulatory body that exists under current legislation requesting it to develop a sexual abuse program and file it with her within three

months. The letter suggests matters to be addressed within the program. It is expected that the plans will form the basis for the sexual abuse measures to be contained in the patient relations programs required under RHPA.

We have also announced our intention to strike an interministerial working group after the final report of the College of Physicians and Surgeons of Ontario Task Force on Sexual Abuse of Patients is delivered to the CPSO council. This is now scheduled for late November.

The working group will study the recommendations and conduct consultations on them with all health professions and with consumer and public interest groups. Legal experts will also be consulted, because the recommendations are likely to raise important Charter of Rights and administrative law issues. The group will, of course, be interested in the response of CPSO and the medical profession overall. However, the problem of sexual abuse is not unique to medicine. One great advantage of this legislative framework is that it enables us to deal comprehensively with all regulated professions. We therefore must consider the issues as they apply to all professions and listen to their viewpoints.

We do not want to delay third reading of these bills to capture the results of these consultations. After so many years of discussion and effort, we want to get them in place so that the hard work of implementation of the legislation can begin, but we will not hesitate to reopen the RHPA to make necessary amendments.

We think statutory provisions should be effective. There is no use in enacting provisions that will not really prevent sexual abuse or deal effectively and appropriately with perpetrators. Also, we must be realistic in what the legislation can achieve. Statutory provisions alone will not ensure that complainants are dealt with compassionately by college officials. A certain climate has to be created.

The Chair: In order that we can deal with all the amendments that have been placed before us, let me ask for unanimous consent of the committee to reopen section 6 and section 11. As well, there is a new proposed section 31.1 and a section 39. If we can have consent so that we can accept the amendments, we will move forward. All in favour? Any opposed?

Agreed to.

Mr J. Wilson: Could I take a few minutes also before we get into the whole area?

The Chair: Yes.

Mr J. Wilson: As members know, the Progressive Conservative Party of Ontario is also committed to the philosophy of zero tolerance of sexual abuse of patients by medical doctors and other health professionals. We believe many college procedures and policies should be changed to be more effective and sensitive to such abuse, and we

are concerned that the regulated health professions legislation as currently drafted does not wholly reflect the zero tolerance philosophy. Of course, that is the object of today's debate. We commend the College of Physicians and Surgeons of Ontario for endorsing the zero tolerance philosophy.

As background to this, I just want to remind members that when doctors take on the responsibilities of life and death they also take the Hippocratic oath, which enshrines them with absolute trust. The oath reads in part as follows, "In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially free from the pleasure of love with women or with men."

As members know, the preliminary report of the Task Force on Sexual Abuse of Patients made a series of recommendations to change the legal and legislative systems to correct the bias against sexual abuse victims. I, along with my colleagues, am looking forward to reviewing the final report of the task force, as I know all members of this committee are.

I will just remind members too that Ernie Eves, the member for Parry Sound, my party's former Health critic, has shown a great deal of initiative in this area. On June 17, 1991, he introduced a private member's bill that would revoke the licences of physicians found guilty of sexually abusing their patients. Mr Eves began drafting the bill after the Task Force on Sexual Abuse of Patients released its preliminary report at the end of May. He has maintained that the fact that the former Minister without portfolio responsible for women's issues and the Minister for Northern Development and Mines felt they had no other recourse available to them than to personally interfere in a quasi-judicial process shows the gaping holes in the system dealing with sexual abuse by physicians. I will be introducing a number of amendments today to deal with this very matter.

Members know we will be introducing an amendment to really help victims. I noted in the parliamentary assistant's comments that he talked a lot about preventing, with corrective measures afterwards. We believe very strongly that a survivors' compensation fund is a cornerstone in effectively dealing with sexual abuse. We will get into that a little further as we get into the amendments.

Ms Poole: This is certainly a very important area, not only for this committee but for society as a whole, because what we are really looking at is changing attitudes and behaviour in society. It is perhaps more important when we are looking at the health care profession because there is an element of trust and respect involved. It is particularly important that patients be protected against any type of sexual abuse or misconduct.

I welcome the opportunity to join the committee today to speak to a number of amendments that are going to be put forward. It is my hope that these amendments will make interim report of the Task Force on Sexual Abuse of Patients come alive and will really trench in the legislation an opportunity for the further amendments of the task force to come alive in future days.

Rather than speak at length right now, I would just like to indicate that the Liberal caucus is very supportive of

measures to bring responsibility and sensitivity to the area of sexual abuse of patients in the health care field and that we feel our amendments will go a long way towards protecting the rights of those patients.

The Chair: I think it would be appropriate if we began with section 6.

Section/article 6:

The Chair: Ms Poole moves that section 6 of the bill be amended by adding the following subsection:

"(1.1) The advisory council shall report to the minister, within five years after this section comes into force, on the effectiveness of,

"(a) each college's patient relations and quality assurance programs; and

"(b) each college's complaints and discipline procedures with respect to professional misconduct of a sexual nature."

Do you wish to speak to the amendment?

Ms Poole: Just briefly, Madam Chair. I think it speaks for itself, but I would also like to mention that this amendment does not put anything on hold for a five-year period. What this amendment does is make sure that certain programs have to have a mandatory five-year review. In the meantime, many reports will be tabled and certainly the college's patient relations will be subject to ongoing review.

Again we come back to the fact that the Task Force on Sexual Abuse of Patients does want us to act and does recommend that we act, and act quickly. We cannot wait for five years. What this amendment does is make sure that at the end of the five-year period there is a review to make sure that what has been put in place is very effective.

Mr Wessenger: I would just like to say that we will be supporting this amendment because it adds to the effectiveness of the legislation by bringing in this mandatory review period to ensure that the programs are working well during the period.

Mr J. Wilson: I would like to indicate to committee members at this time that we will also be supporting this amendment.

Motion agreed to.

Section 6, as amended, agreed to.

L'article 6, modifié, est adopté.

Section/article 11:

Mr Wessenger: I would like to ask that the clause 11(d) amendment be withdrawn as it will be covered by the other amendments to be made.

The Chair: It is withdrawn.

The Chair: Ms Poole moves that section 11 of the bill be amended by adding the following subsection:

"(2) It is the advisory council's duty to monitor each college's patient relations program and to advise the minister about their effectiveness."

Ms Poole: Again, this amendment speaks for itself. I do not think committee members can underestimate the importance of monitoring programs, particularly the college's patient relations program, to ensure that it is effective. This is

just a safeguard put in to make sure that a monitoring process does take place.

Mr Wessenger: I would just like to say we will be supporting this amendment because we think it is an appropriate role for the advisory council.

Mr J. Wilson: I wonder if it would be appropriate at this time for the parliamentary assistant to tell us a little bit more about the patient relations program and the patient relations committee, since we are now getting into voting on that.

Mr Wessenger: Yes. I just wonder if we are a little premature at this time since it will be the subject of later amendments.

Mr J. Wilson: This amendment before us now deals with the patient relations program, the monitoring role of the advisory council, and to support it would be to support the patient relations program. I would like to know exactly what I am supporting, especially in terms of comments with regard to how this program will help victims of sexual abuse.

Mr Wessenger: I can give you an indication of a future amendment that likely will be brought today which is going to establish a patient relations program. The program must include measures for preventing or dealing with professional misconduct of a sexual nature, and there have been some guidelines for what the program should include. For instance, it should set out educational requirements for members, guidelines for the conduct of members with their patients, training for the college staff and the provision of information to the public.

1550

Mr J. Wilson: As you know, also in the future amendments is our amendment for a survivors' compensation fund. Is there any contemplation in the patient relations program or the patient relations committee of authority to compensate victims of sexual abuse?

Mr Wessenger: Our position is that it is premature at this time, that the fund is something that is going to be considered in the whole consultation aspect. It will be an aspect of the further consultation, at least in our position with respect to a survivors' compensation fund.

Motion agreed to.

Section 11, as amended, agreed to.

L'article 11, modifié, est adopté.

The Chair: It is my understanding, just as we are going through the sections, that we are still holding down section 31.1 as well as section 39—those are the native issues—until the end of the full package of bills, the end of Bill 64, as was previously agreed.

Mr Wessenger: Yes.

Schedule/annexe 2:

Section/article 9:

The Chair: Mr Wessenger moves that section 9 of schedule 2 of the bill be amended by adding the following paragraph:

"7. Patient relations committee."

Mr Wessenger: This is to add, of course, one of the required committees, the patient relations committee, of each college.

Ms Poole: I simply want to say that the Liberal caucus will be supporting this amendment. We think the patient relations committee is an excellent idea and are looking forward to fleshing out what the patient relations committee is going to be responsible for.

The Chair: We note there is a further amendment to be tabled. However, at this time, I think it is best, if all members agree, that we deal individually, amendment by amendment, as we go through—Mr Wilson, speaking to this amendment only.

Mr J. Wilson: Again, dealing with the patient relations committee, I ask the parliamentary assistant, since I do not think you have been very specific to date on what exactly this committee will be doing, do you see a survivors' compensation fund as being outside the authority of this committee or something maybe we could agree upon today as a role the committee would see?

Mr Wessenger: I think the committee is obviously going to establish a program within each college for dealing with the problems of sexual abuse. At this time, we do not see it dealing with the issue, but a college could come up with its own individual program of how it wants to deal with the matter of sexual abuse. There may be a lot of similarities in the college's programs, but there may be some unique features with each college in the approach it takes, and hopefully that will guide us with respect to developing a more comprehensive program.

Mr J. Wilson: It is just so vague. I am still not convinced you did not come up with this patient relations committee as a result of our putting forward—we did so first and made it very clear to Marilou McPhedran that we would be putting forward a survivors' compensation fund. It just seems so vague as to what this patient relations committee will be doing. It is like it was an afterthought.

Mr Wessenger: I do not think it is vague. Very clearly, it is going to set out the policy of the college with respect to dealing with the problem of sexual abuse.

Mr J. Wilson: But it does nothing for victims.

Mr Wessenger: The whole idea is to prevent the sexual abuse from occurring, and that is certainly the role of the patient relations committee, to develop a preventive program. The complaints and discipline process will deal with complainants, but this committee will be more on the educative and the preventive aspect.

Mr Jackson: That is the concern we have. We have seen too often that the thrust is really purely educational. I truly believe there is a lot of education out there, but if you are going to leave each college to establish a patchwork of procedures and protocols with patient relations programs, leaving each to develop minimum standards of conduct and responses, you have a framework which cannot lend itself to a consistent compensation package. Women suffer substantive psychological damage as a result of the kinds of breach of trust that occurs in this environment, and they

do not automatically have access to health support services and suffer in financial ways as well.

One does not get a sense that the government has thought this thing through at all. Our amendments lead very clearly to recognizing where there has been harm—it has been documented—and that the principle of compensation offers in and of itself a further deterrent to the profession. It is not simply the degree to which their licence may be at risk or their ability to continue to practise, but also the pecuniary aspects that flow beyond that which also are involved in compensation. So I am not encouraged by your view that the purpose of this is educational.

Mr Wessenger: This amendment is purely to establish the committee. It is not to deal with the other aspects of the sexual abuse program. It is to establish the committee to establish programs for each college. I think that is a significant advance, to require each college to establish a program.

Mr Jackson: It may be an advance to you, but it does not advance the issues in Ms McPhedran's report.

Mr Wessenger: We are not debating the aspects of your amendments. Certainly we can debate those aspects when we reach them.

Mr Hope: The amendment talks about putting forward a committee. What I hear the Conservative Party talking about is the structure and the foresight of the committee. I think that is a debate that will take place later on as we develop that policy. Right now it is just a matter of dealing with whether or not there will be a committee.

Mr J. Wilson: That is the crux of it, and I am glad to hear the member agree. I gather the NDP members may agree that the survivors' compensation fund could very well be part and parcel of the patient relations committee and that we might be able to move on that today.

Mr Wessenger: I think it is premature at this time to say. When a compensation system is established, then of course it would undoubtedly be a part of the program.

Mr Jackson: I just to indicate clearly that we consider this a shallow offer to get at a very serious issue and I personally will not endorse the concept because it falls far short of what we believe is required as a standard for this province and a compensation model for victims of sexual harassment and abuse.

The Chair: All those in favour of the amendment? Those opposed?

Motion agreed to.

Section/article 39:

The Chair: Mr Wilson moves that section 39 of schedule 2 of the bill be amended by adding the following subsections:

"(2) A panel may at any time permit a notice of hearing of allegations of sexual abuse of a patient by a member to be amended if it is of the opinion that it is just and equitable to do so and the panel may make any order it considers necessary to prevent prejudice to the member.

"(3) In subsection (2), 'sexual abuse' means conduct that is sexual including, without limiting the generality of the foregoing, improper touching or kissing."

Mr J. Wilson: The reason for this amendment is that we believe the rule that the description of allegations can only be amended to correct errors or omissions of a minor or clerical nature does not allow a victim of sexual abuse, whose memory returns unpredictably and often in a disorganized series, to place before the decision-makers all the relevant information in time to be considered.

Mr Wessenger: We are opposing the amendment not because we necessarily oppose the content of it, but because it is premature at this time. We only have the preliminary recommendation. We still have to await the final recommendation of the sexual abuse task force and also we have to wait for the consultation process.

Mr Jackson: I think the parliamentary assistant's comments betray a lack of understanding of post-trauma experiences of victims in these circumstances. A portion of this legislation accepts a simple rule of justice and either we embrace that concept or we do not. To simply suggest that at some later date we will get to it, in my view betrays a complete lack of commitment in this area. I am sorry; we are talking about basic justice principles as an underpinning to this legislation.

The Chair: All those in favour of the amendment? Those opposed?

Motion negated.

1600

Section/article 9:

The Chair: I am going to go back and call, shall section 9 of schedule 2 carry? That is the previous amendment establishing the patient relations committee. All those in favour? Any opposed?

Section 9, as amended, agreed to.

L'article 9, modifié, est adopté.

Section/article 39:

The Chair: Now we are at section 39 of schedule 2. The amendment to that has not carried, so I am going to call, shall section 39 of schedule 2 carry? All those in favour? Those opposed?

Section 39 agreed to.

L'article 39 est adopté.

Section/article 46:

The Chair: I believe, Mr Wilson, you have an amendment.

Mr J. Wilson: I am going to withdraw this amendment, because we are concerned about the impact of cost to the complainant.

The Chair: So your amendment to subsection 46(1) is withdrawn.

Mr J. Wilson: We do not want to burden the colleges any further with yet another cost, so we will withdraw this. This is schedule 2, subsection 46(1).

The Chair: That is withdrawn.

Section 46 agreed to.

L'article 46 est adopté.

Mr Wessenger: On schedule 2, sections 81.1 and 81.2, I would like to withdraw this as there will be a further amendment.

The Chair: Withdrawn.

Mr J. Wilson: I just have a question. The parliamentary just withdrew schedule 2, sections 81.1 and 81.2?

The Chair: That is correct.

Mr J. Wilson: Where is that dealt with again?

The Chair: It is the next one that is being placed.

Mr J. Wilson: Under the Liberal motion?

The Chair: Yes.

Ms Poole moves that schedule 2 of the bill be amended by adding, before the heading "Miscellaneous," the following sections:

"Patient Relations Program"

"81.1(1) The college shall have a patient relations program.

"(2) The patient relations program must include measures for preventing or dealing with professional misconduct of a sexual nature.

"(3) The measures for preventing or dealing with professional misconduct of a sexual nature must include,

"(a) educational requirements for members;

"(b) guidelines for the conduct of members with their patients;

"(c) training for the college's staff; and

"(d) the report of information to the public.

"(4) The council shall give the Health Professions Regulatory Advisory Council a written report describing the patient relations program and, when changes are made to the program, a written report describing the changes.

"81.2 The Patient Relations Committee shall advise the council with respect to the patient relations program."

For clarification, Ms Poole, under clause (d), did you want it to say "the report of information to the public" or "the provision of information to the public"?

Ms Poole: Just one moment, Madam Chair, I will look at that. It would seem to me to be more accurate to say "the report of information to the public."

The Chair: Because you had it written, I just wanted to double-check.

Ms Poole: Could you amend my motion with a very friendly motion to say "the report of information"?

Mr Wessenger: The amendment I have in front of me reads "the provision of information to the public."

The Chair: That is what is written.

Mr Wessenger: So I would suggest that—

Ms Poole: Did I say "report"?

The Chair: You said "report," but it says "provision" in the written amendment.

Ms Poole: Then I will correct the record and say "the provision of information."

The Chair: Okay. Your intention is that as it is written, clause (d) should say "the provision of information to the public." Is that what you are moving?

Ms Poole: Yes, that is right, Madam Chair. I thought you were giving me gentle guidance as a former Minister of Health, saying, "You really mean 'report'" and who was I to question you?

The Chair: No, I just noticed that you had said "report" and "provision" was written.

Ms Poole: Thank you for clarifying that. Yes, it does say "provision" and it should say "provision."

Basically, the government motion, as you are aware, sets up a patient relations committee, but we in the Liberal caucus felt there should be certain guidelines and criteria attached to that committee. We felt it very important, not only when dealing with physicians—a number of people have used the word "physicians" today—but with all health care professionals, that for all the colleges there be certain criteria that were common when they were dealing with the patient relations program.

The first, "educational requirements for members," is of vital importance. I cannot overstate the importance of educating the public and health care professionals. To me, it is at the root of the problem. Many people do things out of ignorance or because of behavioural patterns that have been established in the past, and it is time we stood up and said, "This is not acceptable," and provided the public and health care professionals with some guidelines on what is acceptable.

That leads, of course, to clause (b), "guidelines for the conduct of members with their patients." There has been far more awareness in the past few years of what is and what is not appropriate, but it is very important that this be spelled out by the colleges in these guidelines.

"Training for the college's staff" again would run hand in hand with the educational requirements. The guidelines and "the provision of information"—you notice, not "the report of information—to the public is all part of this process. This fleshes out to a greater depth what we would like to see in the patient relations program and I certainly think it would march very well with the McPhedran interim report.

Mr J. Wilson: Perhaps I can move an amendment to the Liberals' amendment.

The Chair: In writing? You have to submit it in writing.

Mr J. Wilson: I will be happy to do that as soon as I read it.

The Chair: It is, I see; okay.

Mr J. Wilson: No, I have another one. I just thought it up, independent thinker that I am.

I do not think we are getting anywhere with our survivors' compensation fund, so on behalf of victims of sexual abuse I will try to put some teeth in this amendment. Perhaps it would be to subsection 81.1(3) where you have clauses (a), (b), (c) and (d). I would propose a clause (e), that says one of the measures for preventing or dealing with professional misconduct of a sexual nature must include, "(e) compensation for victims of sexual abuse."

The Chair: We will receive that in writing. Speaking to your amendment to the amendment?

Mr J. Wilson: We are very concerned that perpetrators of sexual abuse are profiting from their offences. Since I

suspect that in a very few minutes the survivors' compensation fund will be voted down, perhaps it would fit into the patient relations program that they also be mandated to actually look at compensation for victims of sexual abuse. From the comments of all parties today, I think that would be something that is amenable to everyone here.

Mr Owens: Just a quick comment around the amendments to (a), (b), (c) and (d): I certainly hope the parliamentary assistant will pass on these recommendations with respect to education to our colleagues in the Ministry of Colleges and Universities because I think one has to begin at that level, at the training point, where a person is becoming a health care professional. To simply have these guidelines in place at the college level is too little, too late, so I hope we will be passing on these recommendations to the Minister of Colleges and Universities that we have to put the kind of programming into the medical schools, into the professional schools, that will deal with this issue. They need to know immediately, if they do not know already, that sexual abuse is an inappropriate activity.

Mr Wessinger: I certainly appreciate and agree that we should have this in the initial training for members of the colleges, as well as in their continuing education programs. I think it should be involved in both aspects. Just speaking to the amendment, we will be opposing it because we believe it is premature at this time.

Mr Jackson: I would like a recorded vote on this section, please.

1610

The committee divided on Mr J. Wilson's motion, which was negated on the following vote:

Ayes/Pour-2

Jackson, Wilson, J.

Nays/Contre-8

Grandmaître, Haeck, Hope, Malkowski, Martin, Owens, Poole, Wessinger.

Mr Owens: Just playing politics.

The Chair: Order, please. We are voting on the amendment. Did you want to speak to this before we are in the middle of a vote?

Mr Jackson: If some rookie wants to shoot off about it, that is his business, but he does not know the history of this issue in this province.

I have a further amendment, Madam Chair. I believe it is in writing before you.

The Chair: Mr Jackson moves that subsection 81.1(3) of the bill be amended by adding the following clause:

"(e) health-related assistance to victims."

Mr Jackson: As I referenced earlier, the issue of a compensation fund is something we strongly support. Its purpose is because there is a variety of medical-related services that are not automatically available to a victim of sexual abuse in this province. Perhaps somehow we can at least acknowledge that health-related support services and assistance will be made available to victims who have been abused or misused in this fashion, as is set out in measures

to combat sexual misconduct. There is not the right to access. This is difficult, where the medical community has broken faith with a victim. Finding those necessary services is not that easy, but it is none the less incredibly important for the victims that they have access to them.

My concern is that this is so caught up in proactive stancing and that the section is caught up in public relations. I am more concerned that we have in place the effective programs that are victim-centred as well. Minimally I ask this committee to strengthen the Liberal amendment by acknowledging that this committee should address the issue of ensuring that once a case has been found and is ruled on, the committee can go beyond that and say, "The following services are required and they should be an as-of-right for a victim in this province."

The suicide rate associated with victims of sexual abuse, where there is professional misconduct, is a growing concern, because they do not have adequate access, let alone having complete costs paid for. It takes years for them to get access to this kind of service. I just feel we could strengthen this section of the Liberal amendment by including that. Otherwise there is no real acknowledgement of how the patient suffers and how we are prepared to address that; it is simply to act as some sort of arbitrator with this relations program and is a public relations gesture at best. I really feel we should be making that kind of a commitment.

Therefore, I would like to have a recorded vote on this, at least as minimal support for the concept of assistance for victims.

Ms Poole: I just wonder if I might ask a question of the member for Burlington South. I wonder if you could be more specific about what type of health-related support systems, assistance and services to victims you would envisage. Obviously certain services would be covered by OHIP. Could you elaborate on where you would like to see it go beyond that?

Mr Jackson: I think I have stated that it is the right to access. We can get into very complex things, such as that where there is a communications difficulty there should be an as-of-right for someone to receive medical treatment and responses in the language he or she can comprehend and that where we are dealing with severely challenged individuals in society they have the appropriate interpretative services so that they understand what the process is doing to them, so that medical treatment is accessible with those kinds of supports where communication is a problem, where language is a problem, and other disabilities. I could go on at length, but if you have read the report, you know there are people who are particularly vulnerable as victims, but then we do not provide the necessary services.

My point is that the health community can make these services available and I believe that victims of sexual assault as a result of professional misconduct should be assured that they are able to receive those treatments. After all, they have to go back to the same medical community for that support. Any program involving helping the profession deal with this issue should also include the special training and the support services those very same

professionals must apply to helping a person who has been broken trust with.

If someone has had a bad experience with a police officer in a rape case, the courts have a system where there is an alternative so that someone does not present himself as a police officer, but when someone breaches trust as a physician, we still have to have somebody with the medical expertise to assist that person, somebody who is still a member of that professional community. Therefore, I would ask that professional community to come up with the proactive support medical services those victims need, and not simply to say, "We'll just have another psychiatrist deal with this," when in fact the first psychiatrist that woman dealt with destroyed that personal relationship.

Mr Wessenger: I will again be opposing the amendment, because I believe it is premature and also I think there are considerable difficulties with the aspect of colleges providing services in this regard individually. I think it is something that should be dealt with in a general way rather than in a specific college way with respect to the treating of victims. I think we have to have that comprehensive approach and not a sort of throwing it piecemeal to a college that would not be in a position to develop that area.

With respect to the matter of information, I would say that is indeed covered. The provision of information to the public would also include an information service to victims.

Ms Poole: While I certainly support what Mr Jackson has said is necessary for dealing with victims and giving them every assistance, I guess I am a little bit concerned about—I do not want to use the word "vague"—the unclear meaning of this particular sentence. When he read it out, I, who am somewhat more aware than maybe some other people of what type of support systems a victim would need, found myself querying what it meant. If I am querying it, I suspect a lot of the colleges would also wonder what specifically was meant by this section, so I think I would have difficulty including it in this amendment.

Mr Jackson: Recorded vote, Madam Chair.

The committee divided on Mr Jackson's motion, which was negated on the following vote:

Ayes/Pour—2

Jackson, Wilson, J.

Nays/Contre—8

Grandmaître, Haec, Hope, Malkowski, Martin, Owens, Poole, Wessenger.

Mr Jackson: Further discussion, Madam Chair?

The Chair: Mr Jackson, you have the floor.

Mr Jackson: Perhaps Ms Poole could be a little more specific about what is meant by "educational requirements for members." We are dealing with the section I was just attempting to amend, and I am unclear as to what she means by "educational requirements for members."

The Chair: It is appropriate in committee for you to place questions of the parliamentary assistant. If you want to discuss it with Ms Poole, yes, certainly.

Mr Jackson: It is her amendment. That is why I was asking.

The Chair: You can speak to it. It is up to her if she wants to respond. Do you want to speak to it?

Mr Jackson: I asked her the question.

The Chair: Any further speakers on this amendment?

Mr J. Wilson: I think the point is that Mr Jackson's amendment was just voted down because it was too vague. What does "educational requirements for members" mean?

Mr Jackson: We are not prepared to pass these unless the persons who support them—if the Liberals, who drafted them, cannot speak to them, then I would be pleased to hear from the parliamentary assistant.

1620

Mr Grandmaître: Madam Chair, I thought we had just voted on Ms Poole's amendment.

The Chair: No, we voted on Mr Jackson's amendment to the amendment. Ms Poole, did you want the floor to speak to the amendment?

Ms Poole: Certainly, Madam Chair. When you are talking about "educational requirements for members," there is a body of thought out there right now on how to deal with sexual abuse and on guidelines for professional members. When you are talking about health-related support systems and assistance to victims, quite frankly that could be as narrow or as broad as one would like. What one college might interpret it as, another might have a completely diverse viewpoint on it.

Mr Jackson: It is clear you do not understand what I mean with clause (e). I am asking you what you mean with clause (a), "educational requirements for members." "Members" are members of the health profession?

Ms Poole: That is right.

Mr Jackson: Okay, we are making progress. "Educational requirements" as they become certified, or post-certification? What are we talking about here?

Ms Poole: What we are talking about in conjunction with the training of the college's staff is having a number of components in an educational program to make sure that people in the health care professions understand not only what is meant by sexual abuse, but what their responsibilities are as members of that health care profession, education about certain aspects of sexual abuse and what it means to our community and our society. Those are things, when I referred to having a common body of knowledge out there right now, on which we do not need to search for a lot of different answers.

The problem I had with your amendment to clause (e) was, is a college going to be sued because it is not providing a certain support system or a certain degree of assistance that another college is? Is it going to create difficulties in that regard? I still think that on clauses (a), (b), (c) and (d) there is already a common body of knowledge. I am not sure I could say that of the amendment you have brought forward.

Mr Jackson: Madam Chair, I am still having difficulty. Are we talking about going to the dental academy for the five years of dentistry, for example, and there are going to be units on the route to certification as a dentist in this province and those will form part of it, as has been suggested by several women's groups? Is that what we are talking about here, or with "educational requirements for members," are we talking about letting them know that, "By the way, it's wrong to do this and we have a committee that we'll haul you up in front of to talk about it"? I am trying to understand it.

The Chair: Mr Jackson, as you addressed the question to the Chair I can perhaps be helpful. As I read this, the amendment by the government establishes a patient relations committee and a patient relations program. The amendment that has been tabled by Ms Poole defines what components there will be of that program. It will then be up to each college and each patient relations program to define how that relates to each individual college and to the profession. It may differ from profession to profession. That is my understanding of the amendment that is proposed. If anyone else would like to enter into the debate to help clarify this for Mr Jackson, I think he would be quite willing to hear what anyone else has to say, but that is how I read it.

Mr J. Wilson: Our bottom-line concern is that this is pretty vague stuff. They are going to set up educational requirements and guidelines for the conduct of members and training for college staff, and as I understand it, between this and a previous amendment, reporting back their progress on this at some point. Perhaps we could have some indication from the parliamentary assistant, to be fair, on what some of the regulations might be around this area. What is the intent behind it? This is pretty vague stuff. My worry is that there is nothing in here, for instance, to address the needs of the victims of sexual abuse. It is pretty pappy, vague stuff and I do not think it does much to really help the whole issue of sexual abuse. Perhaps for the record the parliamentary assistant could tell us what the intention would be from here on.

Mr Wessenger: I would tend to disagree that it is not very substantial. I think this requirement that members take certain courses to retain their licence is a very powerful tool. That is certainly within the framework of what could be involved in educational requirements.

It could involve being part of the ethics course, or a special course on patient sensitivity included in the training of each member of the college, or a requirement that members take continuing education programs in order to retain their certificates to practise. It would also involve the whole question of general information. It would be a comprehensive program, the way I see it, and it is up to the college to indicate that program. I think it is fair to say that there are certain colleges that have a greater problem than others because of the nature of the health services provided.

Ms Poole: Perhaps it would help also if I mention to Mr Wilson subsection 11(2), which we passed earlier, whereby it is the advisory council's duty to monitor each college's patient relations program and to advise the minis-

ter about the effectiveness of those programs. So there is a built-in tool, an ongoing monitoring process whereby if a particular program was not effective it would be brought to the minister's attention very shortly. Second, there is of course the outside limit of five years that has been set for a review of the whole thing. What I am saying is that there are built-in safeguards to ensure the programs are effective.

Mr J. Wilson: I understand the safeguards and in my comments I tried to allude to the amendment we had passed earlier today regarding the safeguards and the role of the advisory committee. But the word "effective" itself is in question. Effective for what? How do you measure effectiveness of this sort of thing? Do you count how many fewer sexual abuses there are? It seems to me in this area that if you are setting up a patient relations program you should put in some teeth other than having the advisory committee reviewing and reporting to the minister. As I say, there is nothing for compensation. There is nothing to ensure victims will be entitled to the services they need.

The Chair: Are we ready for the vote? All those in favour? Any opposed?

Motion agreed to.

The Chair: Mr J. Wilson moves that schedule 2 of the bill be amended by adding, before the heading "Miscellaneous," the following sections:

"Survivors Compensation Fund

"81.3(1) The college shall establish a fund to be known in English as the survivors compensation fund and in French as the fonds d'indemnisation des victimes.

"(2) The survivors compensation fund shall be administered by the survivors compensation fund committee.

"81.4(1) The college shall have a committee called the survivors compensation fund committee.

"(2) The committee shall be composed of three persons, at least two of whom must be members of the council appointed to the council by the Lieutenant Governor in Council.

"(3) The chair of the committee shall be selected by the committee from among its members who are members of the council appointed to the council by the Lieutenant Governor in Council.

"81.5(1) The fund shall be used for the purpose of assisting patients and former patients who have been victims of professional misconduct of a sexual nature by members or former members."

"(2) The committee may make payments from the fund for treatment or counselling related to the misconduct and for associated expenses.

"81.6(1) A member or former member who is found to have committed an act of professional misconduct of a sexual nature with respect to a patient shall pay into the survivors compensation fund any fees received for services rendered to the patient in the period during which the misconduct occurred.

"(2) An amount required to be paid under subsection (1) is a debt that may be recovered by the committee in a civil proceeding."

1630

Mr J. Wilson: This came out of discussions with Marilou McPhedran and the preliminary report of the Task Force on Sexual Abuse of Patients that was established by the College of Physicians and Surgeons of Ontario. I do not believe, as the parliamentary assistant said in his remarks on voting against our previous amendments, that this is premature. Ms McPhedran has made it very clear to all parties that this concept and the idea of a fund will be very much part of her final report. She has let us know that and has certainly made it clear publicly.

I guess the task force found that abusing medical doctors who abuse have often continued to bill OHIP for the time spent sexually exploiting their patients. This, we are hearing now, applies to some other professions, not just to physicians. Recovery from sexual abuse is often enormously difficult, requiring very specialized care which is seldom readily available and fully funded by OHIP, and that was the point of Mr Jackson's amendment a few minutes ago. We do not want the perpetrators of sexual abuse to continue to profit from their offences.

This amendment requires that each college establish a fund to be known as the survivors compensation fund, and it will be administered by the survivors compensation fund committee. It is much along the same lines as the law society fund. The fund is to be used for the purpose of assisting patients and former patients who have been victims of professional misconduct of a sexual nature by members or former members of the college.

The committee is to make payments from the fund for treatment or counselling related to the misconduct and for associated expenses. A member or former member found to have committed an act of professional misconduct of a sexual nature will be required to pay into the survivors compensation fund any fees received for services rendered to the patient in the period during which the misconduct occurred.

Just to wind up, the patient relations committee, which other members have voted in favour of this afternoon, is designed, as we see it, to prevent professional misconduct of sexual abuse, but in no way will it help those who are victims of sexual abuse. The survivors compensation fund is designed to help victims. I am all for prevention, but we cannot turn a blind eye to the victims.

Mr Wessinger: We will be opposing this amendment because there is a consultation process that has to go through after the final report becomes available. First, this report goes to the College of Physicians and Surgeons. Second, it will go out to all other health professions for consultation. After that, it will go out to interest groups for consultation, and finally it has to be reviewed by legal counsel to ensure that the proposals and changes comply with the Charter of Rights and administrative law requirements.

Ms Poole: When I read over this amendment I guess it offers more questions than it actually answers, when it talks about forfeiture of fees in sexual misconduct, for instance. Those fees of the person who has perpetrated the act would go into the survivors compensation fund, but I am not sure exactly how the fund is set up to receive other

donations to it. If it only relied on what the person accused of professional misconduct put into it as his or her fees received for services rendered to the patient in that period, then obviously it would not be a very healthy fund.

I do not know where the money would come from. I do not know if each college would be responsible for funding this fund individually. I do not know what kind of rules would be set out for the type of remuneration and reimbursement. As you said, some of these questions could probably be answered now, but they are certainly not obvious on the surface of it.

But I am also concerned that when we set up a survivors compensation fund it be as effective as possible, that it does not leave any room for loopholes or errors or possibilities that the fund would not be administered properly. To this effect, I would like to see the final version of the McPhedran report. I would also like to see a consultation process, not only with the various colleges and various professionals but also with some of the victims, to see what they envisage as an effective survivors compensation fund.

While I think the idea is an excellent one, I think it may not have been fleshed out enough quite yet, and I would like to see that when it is put in place it is very effective and does what we really want it to do. Right now, I think it is somewhat premature to expect that we can do that.

Mr J. Wilson: Ms Poole has brought up some very good points. When we sat down to draft the wording of this amendment with Ms McPhedran, we too had similar concerns. That is why we put in the survivors compensation fund committee, which will have some flexibility. It is clear where the money is coming from. We too have concerns that it may not be enough money, but the way it is worded here does not rule out the survivors compensation fund committee bringing forward other suggestions on how the fund may operate.

Ms McPhedran was trying to model it after the Law Society of Upper Canada's fund. Every lawyer pays into a fund, to which grieving clients may apply as a remedy for various harms against them. That is the idea here, that victims will actually be able to be compensated, that survivors of sexual abuse will actually receive some compensation to help with further treatment they may need, often treatment that is not covered by OHIP under our current system.

We believe it is actually doing something, rather than setting up reports and spending a lot of time—prevention is important, but we know it is out there; we know the sexual abuse task force will come back with a similar recommendation. You could spend years consulting on this. We have spent years doing nothing about helping victims of sexual abuse, and it is time we did something.

Ms Poole: Madam Chair, may I ask for a clarification of Mr Wilson's comment? He also mentioned his concern that there might not be enough in the fund. Could he clarify for me whether every member of the college would be subject to a payment into the fund or whether it would rely

solely on the fees of the person who had engaged in professional misconduct?

Mr J. Wilson: We envision both, not only that every member will pay into the fund but also ensure that any fees received during the time a member of the college was found to be sexually abusing a patient would have to be turned over to that fund. I believe there are documented cases of sexual abuse going on for some 25 years. That would be a lot of fees that particular professional received. In one case I was reading about recently, the member of the college was found to be guilty of sexual abuse over a 25-year period, twice a week. He indeed profited from that harmful relationship with a patient. I believe there are a number of similar horrific stories out there to be told.

1640

The Chair: In light of Mr Wilson's comments, what I have just heard is that this amendment would have financial implications for the Treasurer.

Mr J. Wilson: No.

Mr Jackson: No. I appreciate counsel's attempt at directing the Chair in this matter, but our amendment, with its four-page supplement, would indicate it is driven by the college.

The second source of revenue for this fund would come from penalties through criminal charges the crown would lay. Currently that model is sitting in limbo in the office of the Attorney General of this province. We are the last province to comply with criminal penalties being put back into these funds. We are simply providing an option that is being implemented in other jurisdictions for dealing with criminal activity. It is a criminal act to sexually assault someone.

The Chair: In light of that clarification, there is no suggestion that there would be a charge on the Treasurer. I accept that.

Mr J. Wilson: Madam Chair, you raised a very good point. When I read it into the record, under subsection 81.3(2), I said "Administered by Treasurer." That should be deleted and it should say "Administered by Fund Committee." The first draft did envision the Treasurer being involved.

The Chair: Are you amending your own amendment?

Mr J. Wilson: Yes.

The Chair: I have been advised by the clerk that it will be amended appropriately. "Administered by Treasurer" would be considered a margin note that does not form part of the bill, so it is not a requirement. You have specified that it would be administered by the committee, so that is acceptable as it stands.

Mr Jackson: The genesis of this section is not only through the outstanding work of a committee in this province in response to a clearly defined, documented need for the monitoring of and appropriate response to this criminal activity; we seem to be making a commitment to ensure that the public is aware there is a structure in place to make sure the colleges are advised of how wrong this is, but in the wake of that we are still doing nothing for the victim. It strikes me it is an odd paradox in our province that we

have a compensation fund for people who invest in taking a trip. All the travel agencies contribute to a little fund so that when a charter travel company gets into financial difficulty people can be compensated for their loss. That principle has been applied to commercial goods throughout North America for many years; we were one of the first jurisdictions.

A growing number of jurisdictions in North America are now looking at victims' compensation from two sources: from the professional group in which the misconduct originated, and ultimately from court award settlements that include fine surcharges which are put into these types of funds.

If the members of the Liberal Party who are expressing difficulty with the technical problems associated with this were more aware of these human needs in terms of compensation for victims, perhaps we might be able to garner their support. But in no way should that lack of understanding or information about this important issue be, in and of itself, the reason for not supporting it. As I said earlier, particularly for violent crimes, there is a national program, and our province has been hesitant in implementing the fine surcharges. I ask for no less for the children and the women who are the primary victims of sexual assault, that they be given at least a fund from which they can be assisted with their medical needs which, I have to underscore, is still not a guaranteed right in this province.

Victims in other provinces have the right of access to health-related services when they have been victimized by the very professionals they are seeking help from. In that context, not to proceed along this route when other provinces clearly are, in my view flies in the face of what the citizens of this province deserve.

God only knows, in the last round of negotiations with the Ontario Medical Association, the government was able to indicate to it that maybe the liability insurance is a burden, and that some of our fee structure transfer payments to its payment schedule will help offset that. It strikes me that if we have the level of political commitment to ensure liability insurance for a profession, surely we can expect the profession to help fund compensation with its own fees when one of its colleagues performs in such a heinous fashion.

I cannot underscore how important an issue this is for our caucus, and the Chair herself would be very much aware—as the government has no veteran members here—of the level of commitment that has been enunciated in this area. Therefore, we ask for a recorded vote on this amendment as well.

Ms Poole: Quite frankly, I take offence at the words of the member for Burlington South when he talks about the Liberal caucus having a lack of information and understanding on the issue.

Mr Jackson: I was referring to you personally, not to your whole caucus. I want to make that straight; sorry.

Ms Poole: I take even greater offence then, Mr Jackson.

Mr Jackson: Fine.

The Chair: Order, Mr Jackson. You do not have the floor.

Mr Jackson: I apologize, Madam Chair.

Ms Poole: Quite frankly, I do not think it shows any lack of understanding of the issue when we are pointing out problems and problematic features of the survivors compensation fund. Your own colleague has admitted he is concerned about the funding.

Mr Jackson: "I do not think doctors will cough it up," is what you are saying.

The Chair: Mr Jackson, you do not have the floor.

Ms Poole: I read this amendment and the only source I see of payment into the fund is by a member or former member who has been convicted of sexual misconduct. Now, how far is this fund going, Mr Jackson, if that person has had one trip to the doctor, at which time the sexual abuse occurred, and there is all of \$60 put into the fund? I do not think that is going to go very far. Quite frankly, I would rather vote against what I think is a faulty amendment that does not go far enough in providing victims with real compensation than to just throw something out to make Brownie points, without really having consulted or gone into any depth.

I would be the first to urge the government to proceed with something along this line, but I want to make sure that when we do it, it is done properly. So I take great offence at your comments because I am trying to provide some discussion base for what I feel needs improvement in this amendment.

Mr Jackson: Madam Chair.

The Chair: I am sorry, you do not have the floor. I will put you on the list, if you wish. Mr Hope, then Mr Wessenger, then Mr Wilson, then Mr Jackson.

Mr Hope: I agree with Ms Poole on this whole issue. We may be rookies but some of us do know what we are talking about. When we talk about helping people in our communities, we do not need to be politicians to understand that.

When I look at the issue of compensation, it is nice that we establish a fund, but it is the mechanism and how that fund has generated revenues put in there. I heard a comment from Mr Wilson about a person who was victimized for 20 years, two times every week. I would like to know how we are going to get that revenue out of there. It talks, in the last part, about civil proceedings. Civil proceedings could take some time, and by the numbers and the sincerity of what is taking place, there are a lot of people out there being victimized.

1650

Where I really have concern is that we are premature on the report. The report has not come back and added proper dialogue. The other concern I really have is that we have identified a survivors compensation fund, but what if there are no revenues there and somebody is victimized? Where is our recourse? Do we say, "Sorry, we're out of money and there are no revenues available"? One of the questions the committee will have to deal with is, how do we get revenues in there to make sure that the safety of people is there, that people will come forward with a lot of the issues they have?

Mr Wessenger: I would just like to make it clear that we are not rejecting the concept of compensation for survivors at all with respect to this matter. We want to ensure that the matter of compensation for survivors is done in a workable manner that works best for the victims.

Mr J. Wilson: It sure sounded like you were copping out. I gave the committee an out in my first amendment to the Liberal motion, which simply said "compensation for victims." Had we introduced clause (e) to your amendment it would have been fine, but what I am hearing is that the NDP and the Liberals are not committed. I do not think you are committed to the principle. If there is a problem with a particular clause here in terms of you want it specified where more people pay into this fund or what the fees would be, we can work with that and introduce amendments. There is no reason this has to be done today; there is no definitive time line here.

As for Brownie points, the history of this is that we brought forward our survivors compensation fund before the government gave any indication it was going to do anything about this issue. I know very well how the behind-the-scenes play worked. I met with Marilou McPhedran one day. That next morning she met with the minister, and a week later the minister says, "Okay, we're going to do something about it," because Marilou told me. She told me: "You guys are going to bring forward a compensation fund. Thanks very much for bringing it forward because you are helping to force the government to adopt our agenda." That is the politics of it, so the Brownie points argument is just God-awful, and I hope people will refrain from bringing that forward.

Ernie Eves brought forward a private member's motion some months ago that has real teeth to it in dealing with the licences of physicians who are found guilty of abusing patients. It is a very serious private member's bill. Our caucus is extremely committed to this. We have been on the record for several months now, in fact since last year. The political history of this, I think, is now clear.

I would simply say to members to introduce amendments if they have problems with one or two sentences in it, but the principle is extremely important and I certainly ask for their support.

Mr Jackson: I hope Mr Hope did not misunderstand my statement about the rookies. Last Thursday in the House we talked about the fact that they are refreshing because they do not know all the history. The issue was the vaccine-damaged children's compensation fund, which we had been working on for six years. What I was saying was that you would have been aware, if you had sat in the House for the last six years, that this matter has come up time and time again and it has been advanced, consistently, from our perspective.

The fact that the Liberals did not see fit to support these principles was the point I was making, not that there is anything wrong with being a new member of the Legislature. I just want to make that point clear. It was simply that you would be more intimately aware of the struggle that has been going on to get these principles of compensation for

victims of sexual assault entrenched. It was resisted by the former government, and that is a matter that can be interpreted openly for those who were members of it.

Ms Poole has indicated concern with not understanding the intent and the framework of a compensation fund. All she had to do was move two or three pages farther, to section 91.1, where it indicates it is a surcharge. There are many programs I can refer to. With the travel compensation fund in this province, when it drops below, there is a surcharge to all the members and the members have to define it. But I can tell you that in the travel industry, they weed out bad operators. They change their rules. They modify their conduct. I am simply saying that a system based entirely on public relations and prevention does nothing but reduce the incidence, but there will continue to be incidents and those victims are the people who require some support.

Had you simply agreed that these committees we previously approved could at least suggest a compensation system or a recognition of the victim's needs, and if you could put those two generally worded principles in the bill and then turn to the government of the day and say, "Now you have some time to put in regulations. Now you can develop these programs," and if you had given just a morsel in this legislation for those victims, we would not be pushing this fund. But we are not getting anything. If the parliamentary assistant says he is committed to the principle and the concept, he had his opportunity 20 minutes ago to amend the previous Liberal motion about the patients relations program, but it is not even on the agenda for that committee.

I do not want to be called off topic because we had our opportunity to have a victim-centred concern raised in that environment. As I look through that, I do not see that. I see prevention, public relations and public education. We are fooling and deluding ourselves if we think anything we have done is going to help the victims who are in the wake of this.

Morally, I have difficulty that we have opened up this bill. Probably, if history serves us well, it will be 20 more years before we get a chance to open this bill again. While in this short time in our province's history we can open up this bill, I have to put those concerns on the record with a recorded vote, because today, tomorrow, there will be cases of victimization and we will continue to pay lipservice to victims in this province.

We have the lowest access rate for criminal injuries compensation for women in this country, and sexual assault is the worst category. Here we have an opportunity where the profession is willing to publicly admit that it wants zero tolerance. We should be putting in this fund. I appeal to the parliamentary assistant, replete with his marching orders, that if he really was committed to this, then he would have approved the amendment on the patient relations committee. It is clear he has not.

Mr Owens: I think the member of the third party is fully within his rights to call for a recorded vote on this issue, but simply because we do not support the third party's amendment is clearly no indication that we are not

in support of victim compensation or victims' rights. I think it is a fallacious statement to make that kind of association.

Mr Jackson: I apologize. Could you please show me what page your amendment is on?

The Chair: Mr Jackson, you do not have the floor. I am going to have to call for order.

Mr Owens: These hearings have been distinctly non-partisan up until this point.

Mr J. Wilson: Up until you ruled out every one of my amendments.

The Chair: I am sorry, Mr Wilson, you do not have the floor. I would ask for order from the committee members. Through the hearings today, I think all members have had the opportunity to be heard when they have been speaking. I would ask that you give Mr Owens the courtesy of listening to his remarks.

Mr Owens: I think I have made my views known.

The Chair: Mr Hope, did you want to comment or can we take the vote.

Mr Hope: Just a quick comment. I will not be intimidated by the opposition because I have no use for that. There is a very serious concern here. What I am saying is there has been a suggestion made that the government is abandoning it. Is it not true that under an amended section we just did, schedule 2, sections 81.1 and 81.2, where it talks about report of the program and the program itself, if the survivor or compensation spouse comes forward, we can introduce it under regulations, which makes flexibility there on implementing the program?

1700

Mr Wessenger: I think it is very difficult to have a levying of fees, Mr Hope, without explicit authority in the act, with respect to your question. I could not see, under the existing amendment that has been passed, that it would authorize such action. I think there is no question that the whole problem of sexual abuse is prevalent throughout our society. It is not just the regulated health professions that are the problem; there is also a problem with respect to the unregulated health professions. I think what we are all looking for is the most appropriate solution and we need to go through the process to make sure we get it right.

The committee divided on Mr J. Wilson's motion, which was negated on the following vote:

Ayes/Pour-2

Jackson, Wilson, J.

Nays/Contre-6

Hope, Malkowski, Martin, Owens, Poole, Wessenger.

Section/article 85:

The Chair: Mr J. Wilson moves that section 85 of schedule 2 of the bill be amended by adding the following subsections:

"(3) This section and the Limitations Act do not apply with respect to an action arising out of a person's sexual abuse of a patient while the person was a member.

"(4) In subsection (3), 'sexual abuse' means conduct that is sexual including, without limiting the generality of the foregoing, improper touching or kissing."

Mr J. Wilson: We do not believe there should be a limitation period on sexual assaults occurring in or as a result of a relationship of authority, trust or dependency, in particular with any health care professional. This amendment is in keeping with the draft bill released by the Attorney General on June 27. As part of this bill, the Attorney General is proposing that in cases of sexual assault the limitation period be removed. I understand the government may argue that it is going to be introducing a new Limitations Act. I would say this legislation has not yet been dealt with by the House and now is the opportunity to ensure there will be no limitation with respect to dealing with cases of sexual abuse.

Mr Wessinger: I would like to oppose the amendment, first of all on the basis that we believe it is premature, but more importantly, as far as I am concerned, the Attorney General has circulated a discussion paper on amendments to the Limitations Act. The new Limitations Act will comprehensively set out the limitation periods, including the limitation period for suing health professionals. There are specific provisions set out in that act and I think the most appropriate place to deal with the question of limitations is within one act, the Limitations Act. I must say, as a person who formerly practised law, I think it is important that we have all limitations periods set out in the Limitations Act for the better administration of a legal situation.

Mr Jackson: The problems associated with the Limitations Act should be well known to several members. There are no assurances or guarantees that the matter will be dealt with in an expeditious manner, nor in particular in a sensitive fashion. Here we have a situation where, to my knowledge, I do not believe the medical profession is concerned about the limitations period. Second, there is not a women's group in this province that supports the reduction of the limitations period, especially because of the deep psychosomatic nature of a broken trust as it relates to sexual misconduct.

As to the mindset of the Attorney General's office, I appreciate they are not here to defend themselves, but it was your own colleague Mr Cooke, the former member for Kitchener, who brought in on two occasions amendments to the Limitations Act in the form of bills, not as resolutions, and they were not allowed to be expressions of the will of the House, to proceed for final amendment. I therefore am quite clear about the mindset on this important issue.

Therefore, I must reiterate that in cases involving sexual assault and abuse of children and women, who are the primary victims, a statute of limitations should not be considered. They should be left in accordance with our amendment. I have heard no difficulty from the various health professions with this amendment. It has nothing to do with compensation; it has to do with what value at all we are going to put in this legislation on matters outstanding. We are essentially prejudging. We are, in a sense,

telling the committee that there is a benchmark; that is, we do not wish you to close the books on these matters after 5, 10 or 15 years.

Mr Wessinger: I understand there are no limitation periods set out in the proposed Limitations Act with respect to sexual assaults. I had understood, certainly from our counsel, that Marilou McPhedran was actually supportive of dealing with this matter through the Limitations Act, or at least supported the changes to the Limitations Act.

Mr Jackson: It is precisely on that point that I would like it clear in this that we are saying there will be no limitations. We know that in the Attorney General's office they have expressed clear opinions, which are very well documented, around incest and sexual assault. I am not encouraged by that mindset. We all know these bills tend to be amended. Notwithstanding anything they may come up with, it is simply a principle and a line we wish to draw, that there should be no limitations in these matters.

Mr J. Wilson: I have a quick question to the parliamentary assistant. Do you know what the time frame is for the Attorney General's proposed Limitations Act?

Mr Wessinger: Going by memory, I believe there was supposed to be approximately a year's consultation period. I am just going from memory. It has been out for at least six months.

Mr J. Wilson: What would the current limitation be in the area of sexual abuse?

Mr Wessinger: I will ask counsel. Under the present Health Disciplines Act, there is a one-year limitation period from when the person discovered it.

Mr J. Wilson: Do you have any worry that the victims of the sexual abuse going on today are possibly going to be denied a degree of justice when there is no definite time frame as to when a new Limitations Act will come in?

Mr Wessinger: One of the problems is that people do not sue for civil liability with respect to the matter of sexual abuse. In fact, civil liability has not proved an effective method of dealing with the matter of sexual abuse. That is why it has to be dealt with by other means.

The Acting Chair (Ms Poole): Just before we go to Mr Jackson, Mr Owens.

Mr Owens: I yield my time.

Mr Jackson: What I am hearing is that because we have a one-year limitation from the time it has become known, we should not be very surprised that people do not resort to the courts.

Mr Wessinger: No, that is not the reason. The basic fact is that the court system is so expensive and so cumbersome for most people that they do not resort to the court system in situations involving sexual abuse.

Mr Jackson: But the limitation period is a function.

Mr Wessinger: No, I do not think the limitation period is the basic problem. The basic problem is that people are inhibited from taking the civil process by the cost and the complexity. It is not the Limitations Act that is the

court system is not the method that is going to work with respect to dealing with this matter.

1710

Mr Jackson: Some of the models for justice reform in other jurisdictions in Canada and one that is currently before the current Attorney General for consideration is that matters of civil litigation in these matters could be supported with public funds and/or that ultimate costs are borne by the accused. All that we are simply suggesting here is that if your government is prepared to have an open-ended limitations period, but it might be a year or two or three years down the road, clearly we are defining two sets of justice opportunities for citizens, based on which side of amendments to the Limitations Act they fall on.

We are simply freeing those victims from being encumbered by the current restrictions of the Limitations Act, which is something you again say that you are committed to and can very simply implement with this statement. I believe we are offering you an opportunity to not incur a great expense, but to make sure that victims today are treated the same as victims will be treated three years from now when we finally get around to finishing the Limitations Act. That is all we are suggesting here.

We would like a recorded vote on this one, that is for sure.

Mr Wessinger: I think it is fair to say that when the Limitations Act amendments are passed this legislation will be retroactive, so people will benefit from it when it is passed.

The committee divided on Mr J. Wilson's motion, which was negated on the following vote:

Ayes/Pour-2

Jackson, Wilson, J.

Nays/Contre-5

Haeck, Malkowski, Martin, Owens, Wessinger.

Section 85 agreed to.

L'article 85 est adopté.

The Acting Chair: The next amendment is a Conservative motion.

Mr J. Wilson: Madam Chair, we will be withdrawing this amendment grudgingly and with regret, since the survivors compensation fund amendment did not pass.

Mr Jackson: But the Chair is now aware of how we would fund it? Great.

The Acting Chair: Shall section 91 carry?

Sorry, before I do that, there is a motion that is necessary because of another motion which passed today, and that is to rescind a previous motion.

I move that the vote on the government motion dealing with paragraph 22.1 of subsection 91(1) of schedule 2 of the bill and subsection 91(2) of schedule 2 of the bill be rescinded.

Mr J. Wilson: Will you repeat that, Madam Chair?

The Acting Chair: Earlier in the proceedings today we passed sections 81.1 and 81.2. Because that motion superseded the previous government motion we need a motion to rescind the previous motion.

Mr J. Wilson: Understood.

The Acting Chair: I am glad somebody does. Any discussion, or anybody want to clarify their version of this motion?

Mr Wessinger: I understand what you are doing. Your new 81.1 and 81.2 make this—

The Acting Chair: That is right; new 81.1 and 81.2 supersede the old motion. All in favour? Opposed?

Motion agreed to.

The Acting Chair: It is my understanding that when we completed the discussion and the amendments on Bill 43 we would adjourn for the day. Is that the understanding?

Mr Wessinger: No, I think we were going to include the provisions with respect to the acts we have already covered with respect to the patient relations committee. We were going to finish those off and then at that stage adjourn for the day.

The Acting Chair: I thank the parliamentary assistant for that assistance.

AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY ACT, 1991

LOI DE 1991 SUR LES AUDIOLOGUES ET LES ORTHOPHONISTES

Mr Wessinger: We are dealing with subsection 21(4) of Bill 44. We just need to vote on it.

The Acting Chair: The clerk has confirmed that subsection 21(4) of Bill 44, An Act respecting the regulation of the Professions of Audiology and Speech-Language Pathology, has been moved, so we will go directly to the vote. All in favour of subsection 21(4)? All opposed?

Motion agreed to.

Section 21, as amended, agreed to.

L'article 21, modifié, est adopté.

CHIROPODY ACT, 1991

LOI DE 1991 SUR LES PODOLOGUES

Section/article 24:

The Acting Chair: The clerk confirms that subsection 24(4) has been moved. All in favour? All opposed?

Motion agreed to.

Section 24, as amended, agreed to.

L'article 24, modifié, est adopté.

CHIROPRACTIC ACT, 1991

LOI DE 1991 SUR LES CHIROPRACTICIENS

Section/article 22:

The Acting Chair: The clerk confirms that subsection 22(4) has been moved. All in favour? All opposed?

Motion agreed to.

Section 22, as amended, agreed to.

L'article 22, modifié, est adopté.

DENTAL HYGIENE ACT, 1991

LOI DE 1991 SUR LES HYGIÉNISTES DENTAIRES

The Acting Chair: We now move to Bill 47, An Act respecting the regulation of the Profession of Dental Hygiene.

Mr J. Wilson: Is there any way we can just have one motion? They are all different subsections, I guess.

The Acting Chair: We will try to move through them quite quickly.

Section/article 22:

The Acting Chair: Bill 47, subsection 22(4), all those in favour? All those opposed?

Motion agreed to.

Section 22, as amended, agreed to.

L'article 22, modifié, est adopté.

DENTAL TECHNOLOGY ACT, 1991

LOI DE 1991 SUR LES TECHNOLOGUES DENTAIRES

Section/article 21:

The Acting Chair: All in favour of subsection 21(4)? All opposed?

Motion agreed to.

Section 21, as amended, agreed to.

L'article 21, modifié, est adopté.

DENTISTRY ACT, 1991

LOI DE 1991 SUR LES DENTISTES

Section/article 24:

The Acting Chair: All in favour of subsection 24(4)? All opposed?

Motion agreed to.

Section 24, as amended, agreed to.

L'article 24, modifié, est adopté.

DENTURISM ACT, 1991

LOI DE 1991 SUR LES DENTUROLOGISTES

Section/article 22:

The Acting Chair: Shall subsection 22(4) carry? All in favour? All opposed?

Motion agreed to.

Section 22, as amended, agreed to.

L'article 22, modifié, est adopté.

DIETETICS ACT, 1991

LOI DE 1991 SUR LES DIÉTÉTISTES

Section/article 20:

The Acting Chair: Shall subsection 20(4) carry? All in favour? All opposed?

Motion agreed to.

Section 20 agreed to.

L'article 20 est adopté.

MASSAGE THERAPY ACT, 1991

LOI DE 1991 SUR LES MASSOTHÉRAPEUTES

Section/article 21:

The Acting Chair: Shall subsection 21(4) carry? All in favour? All opposed?

Motion agreed to.

Section 21 agreed to.

L'article 21 est adopté.

The Acting Chair: Unless anybody has any other surprises, I presume that is it. Tomorrow, for the information of committee members, we shall be starting on Bill 53 and proceed until that is completed.

Mr Wessenger: And the other bills.

The Acting Chair: And whatever bills are still outstanding.

The committee adjourned at 1721.

CONTENTS

Monday 21 October 1991

Regulated Health Professions Act, 1991, and companion legislation / Loi de 1991 sur les professions de la santé réglementées	
et les projets de loi qui l'accompagnent	S-871
Audiology and Speech-Language Pathology Act, 1991 / Loi de 1991 sur les audiologues et les orthophonistes	S-884
Chiropody Act, 1991 / Loi de 1991 sur les podologues	S-884
Chiropractic Act, 1991 / Loi de 1991 sur les chiropracticiens	S-884
Dental Hygiene Act, 1991 / Loi de 1991 sur les hygiénistes dentaires	S-885
Dental Technology Act, 1991 / Loi de 1991 sur les technologues dentaires	S-885
Dentistry Act, 1991 / Loi de 1991 sur les dentistes	S-885
Denturism Act, 1991 / Loi de 1991 sur les denturologistes	S-885
Dietetics Act, 1991 / Loi de 1991 sur les diététistes	S-885
Massage Therapy Act, 1991 / Loi de 1991 sur les massothérapeutes	S-885

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Le mardi 22 octobre 1991

Standing committee on social development

Regulated Health
Professions Act, 1991
and companion legislation

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent

Chair: Elinor Caplan
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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 22 October 1991

The committee met at 1537 in room 151.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Suite de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

The Chair: I call the committee to order. I suggest we complete the work we were doing yesterday. Shall Bills 44 to 52, as amended, carry? All in favour? Any opposed? That is carried. We have fully completed Bills 44 to 52.

MEDICAL LABORATORY TECHNOLOGY ACT, 1991

LOI DE 1991 SUR LES TECHNICIENS DE LABORATOIRE MÉDICAL

The Chair: We are going to begin deliberations on Bill 53.

Section/article 1:

Mr Wessenger moves that the French version of section 1 of the bill be amended,

- (a) by striking out "techniciens" in the definition of "ordre" and substituting "technologistes"; and
- (b) by striking out "technicien" in the definition of "profession" and substituting "technologiste."

Motion agreed to.

Section 1, as amended, agreed to.

L'article 1, modifié, est adopté.

Section/article 2:

The Chair: Mr Wessenger moves that the French version of subsection 2(2) of the bill be amended,

- (a) by striking out "techniciens" in the definition of "ordre" and substituting "technologistes"; and
- (b) by striking out "technicien" in the definition of "profession" and substituting "technologiste."

Motion agreed to.

Section 2, as amended, agreed to.

L'article 2, modifié, est adopté.

Section/article 3:

The Chair: Mr Wessenger moves that section 3 of the bill be struck out and the following substituted:

"3. The practice of medical laboratory technology is the performance of laboratory investigations on the human body or on specimens taken from the human body and the

evaluation of the technical sufficiency of the investigations and their results."

Mr Wessenger: This amends the scope of practice to reflect the fact that some lab tests are performed directly on human body skin and not on specimens. It also clarifies that technologists evaluate the technical sufficiency of the results of tests and of investigations.

Motion agreed to.

Section 3, as amended, agreed to.

L'article 3, modifié, est adopté.

The Chair: Mr Wessenger moves that the bill be amended by adding the following section:

"3.1. In the course of engaging in the practice of medical laboratory technology, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to take blood samples from veins or by skin pricking."

Mr Wessenger: This authorizes members to draw blood when the procedure is ordered by a physician or dentist.

Motion agreed to.

The Chair: Mr Wessenger moves that the bill be amended by adding the following section:

"3.2(1) A member shall not perform a procedure under the authority of section 3.1 unless the procedure is ordered by a member of the College of Physicians and Surgeons of Ontario or the Royal College of Dental Surgeons of Ontario.

"(2) In addition to the grounds set out in subsection 49(1) of the health professions procedural code, a panel of the discipline committee shall find that a member has committed an act of professional misconduct if the member contravenes subsection (1)."

Mr Wessenger: This reflects the fact that physicians and dentists are authorized to order lab tests under the Laboratory and Specimen Collection Centre Licensing Act, while other professions, such as chiropractors, cannot make that order. If blood is drawn without an order, it provides for discipline.

Motion agreed to.

Section/article 4:

The Chair: Mr Wessenger moves that the English version of section 4 of the bill be amended by striking out "techniciens" in the fourth line and substituting "technologistes."

And he further moves that the French version of section 4 be amended by striking out "techniciens" in the second line and substituting "technologistes."

Motion agreed to.

Section 4, as amended, agreed to.

L'article 4, modifié, est adopté.

Section/article 5:

The Chair: Mr Wessenger moves that subsection 5(1) of the bill be amended,

(a) by striking out "at least nine and no more than twelve" in the first line of clause (a) and substituting "at least seven and no more than eleven."

(b) by striking out "at least five and no more than seven" in the first line of clause (b) and substituting "at least seven and no more than ten"; and

(c) by striking out "one or two persons" in the first line of clause (c) and substituting "one person."

Mr Wessenger: This changes the council composition to make public members just under half, as agreed with the representation of the college.

The Chair: To the amendment, all those in favour? Any opposed?

Motion agreed to.

Section 5, as amended, agreed to.

L'article 5, modifié, est adopté.

Section 6 agreed to.

L'article 6 est adopté.

Section/article 7:

The Chair: Shall section 7 stand as part of this bill? All those in favour? Any opposed?

Section 7 deleted.

L'article 7 est rayé.

Sections 8 to 13, inclusive, deleted.

Les articles 8 à 13, inclusivement, sont rayés.

Section/article 14:

The Chair: Mr Wessenger moves that subsection 14(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

Mr Wessenger: This is again to extend title protection outside the area of health care.

Motion agreed to.

The Chair: Mr Wessenger moves that the French version of subsection 14(1) of the bill be amended by striking "technicien" in the second line and substituting "technologiste."

And he further moves that the French version of subsection 14(2) of the bill be amended by striking out "technicien" in the fourth line and substituting "technologiste."

Motion agreed to.

Section 14, as amended, agreed to.

L'article 14, modifié, est adopté.

Sections 15 and 16 agreed to.

Les articles 15 et 16 sont adoptés.

Section/article 17:

The Chair: Mr Wessenger moves that section 17 of the bill be amended by striking out "college" in the third line and substituting "council" and by striking out clause (b).

Motion agreed to.

The Chair: Mr Wessenger moves that clause 17(a) of the bill be amended by striking out "number" in the first line.

Motion agreed to.

Section 17, as amended, agreed to.

L'article 17, modifié, est adopté.

Sections 18 and 19 agreed to.

Les articles 18 et 19 sont adoptés.

Section/article 20:

The Chair: Mr Wessenger moves that section 20 of the bill be amended by adding the following subsection:

"(4) Despite subsection (1), section 81.1 of the health professions procedural code, as it applies in respect of this act, does not come into force until one year after this act comes into force."

Mr J. Wilson: I will just indicate for the record that I will be voting against this. It relates to the patient relations committee and program, and we do not believe that committee or program does enough for the victims of sexual abuse.

The Chair: To the amendment, all those in favour? Any opposed?

Motion agreed to.

Section 20, as amended, agreed to.

L'article 20, modifié, est adopté.

Section/article 21:

The Chair: Mr Wessenger moves that the French version of section 21 of the bill be amended by striking out "techniciens" in the second line and substituting "technologistes."

Motion agreed to.

Section 21, as amended, agreed to.

L'article 21, modifié, est adopté.

1550

Title/title:

The Chair: Mr Wessenger moves that the French version of the long title of the bill be amended by striking out "technicien" and substituting "technologiste."

Motion agreed to.

Title, as amended, agreed to.

Le titre, modifié, est adopté.

The Chair: Shall the bill carry? All those in favour? Any opposed? Carried.

Mr Owens: I have a quick comment with respect to the bill we have just gone through. During the hearings process it was brought to our attention by the folks who are involved in medical technology, as well as the nurses, that they face a different situation with respect to their relationship with a college and an employer. I am directing my comments to the parliamentary assistant. Before we finish this process, I hope we will address a method where the discipline process at the college level and at the employer level will run concurrently so that we are not going to get two different decisions at two different times, potentially putting the public at risk and putting the workers' livelihood unnecessarily at risk.

Mr Hope: The Chair just held a vote on the bill, and I am curious whether yesterday we voted on the bills or not. I am wondering why the change.

The Chair: I am sorry. What was your question?

Mr Hope: Yesterday we never voted on the bills as a whole, and today we are.

The Chair: That is right. The bills we vote on as a whole means they are completed and that no sections have been held down to a future date. We have not dealt with Bill 43 because certain sections of that bill are still open. However, yesterday we dealt with the outstanding sections of Bills 44 to 52. Today we were able to complete the call on the bill as a whole, and that is why I called, "Shall the bill carry?"

Mr Hope: But what about those other bills that we completed yesterday?

The Chair: We did that before you arrived at today's session.

Mr Hope: Oh, okay.

The Chair: They were completed. I did not realize you were not here. At the start of today's meeting I called, "Shall Bills 44 to 52, as amended, carry?" and that was carried. Any further questions?

Mr Hope: No, I just wondered why the change.

MEDICAL RADIATION TECHNOLOGY ACT, 1991

LOI DE 1991 SUR LES TECHNICIENS EN RADIATION MÉDICALE

Section/article 1:

The Chair: Mr Wessenger moves that the French version of section 1 of the bill be amended,

- (a) by striking out "techniciens" in the definition of "ordre" and substituting "technologues"; and
- (b) by striking out "technicien" in the definition of "profession" and substituting "technologue."

Motion agreed to.

Section 1, as amended, agreed to.

L'article 1, modifié, est adopté.

Section/article 2:

The Chair: Mr Wessenger moves that the French version of subsection 2(2) of the bill be amended,

- (a) by striking out "techniciens" in the definition of "ordre" and substituting "technologues"; and
- (b) by striking out "technicien" in the definition of "profession" and substituting "technologue."

Motion agreed to.

Section 2, as amended, agreed to.

L'article 2, modifié, est adopté.

Section/article 3:

The Chair: Mr Wessenger moves that section 3 of the bill be struck out and the following substituted:

"3. The practice of medical radiation technology is the use of ionizing radiation and other forms of energy prescribed under subsection 18(2) to produce diagnostic images and tests, the evaluation of the technical sufficiency of the images and tests, and the therapeutic application of ionizing radiation."

Mr Wessenger: The purpose of the amendment is to make clearer the scope of practice for the profession.

Motion agreed to.

Section 3, as amended, agreed to.

L'article 3, modifié, est adopté.

Section/article 4:

The Chair: Mr Wessenger moves that section 4 of the bill be struck out and the following substituted:

"4. In the course of engaging in the practice of medical radiation technology, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

"1. Taking blood samples from veins.

"2. Administering substances by injection or inhalation.

"3. Administering contrast media through or into the rectum or an artificial opening into the body.

"4. Tattooing."

Mr J. Wilson: We will be supporting this amendment, but I would ask the parliamentary assistant why the new amendment no longer contains "on the order of a member of the College of Physicians and Surgeons of Ontario."

Mr Wessenger: I think the next amendment covers the whole matter by saying, "A member shall not perform a procedure under the authority of section 4 unless the procedure is ordered by a member of the College of Physicians and Surgeons of Ontario."

Motion agreed to.

Section 4, as amended, agreed to.

L'article 4, modifié, est adopté.

The Chair: Mr Wessenger moves that the bill be amended by adding the following section:

"4.1(1) A member shall not perform a procedure under the authority of section 4 unless the procedure is ordered by a member of the College of Physicians and Surgeons of Ontario.

"(2) In addition to the grounds set out in subsection 49(1) of the health professions procedural code, a panel of the discipline committee shall find that a member has committed an act of professional misconduct if the member contravenes subsection (1).

Motion agreed to.

Section/article 5:

The Chair: Mr Wessenger moves that the English version of section 5 of the bill be amended by striking out "techniciens" in the fourth line and substituting "technologues."

And he further moves that the French version of section 5 of the bill be amended by striking out "techniciens" in the second and third lines and substituting "technologues."

Motion agreed to.

Section 5, as amended, agreed to.

L'article 5, modifié, est adopté.

Section/article 6:

The Chair: Mr Wessenger moves that clause 6(1)(a) of the bill be amended by striking out "at least seven and no more than ten" in the first line and substituting "at least six and no more than nine."

And he further moves that clause 6(1)(b) of the bill be amended by striking out "at least four and no more than

six" in the first line and substituting "at least five and no more than eight."

1600

Mr J. Wilson: I would just note that I will be voting against this particular amendment because we believe it diminishes the principle of self-regulation.

Mr Owens: I just want to ask the member of the third party how that contrasts with his statement yesterday to the effect that we should have more intrusion into the college process, where we feel that this is self-regulating. The member's statement yesterday seemed to reflect a difference in position.

The Chair: Mr Owens, while it is nice to have your question on the record, in committee you can debate and close it rhetorically. Mr Wilson is not obliged to answer questions, as he is not a witness before the committee, but I am sure that if you ask nicely, he will be happy to answer the question. I have Mr Hope first to speak.

Mr Hope: I think the ability is still there for self-regulation. What the legislation is intended to do is to make sure the public is well informed on what is going on around the colleges and the professionals out there in our health care system, and at the same time to give these the flexibility to make sure they are able to function on a day-to-day basis and be self-regulated. They still hold 51% of the vote.

The Chair: Thank you, Mr Hope. I know Mr Wilson is surprised by your comments at this point in time. Mr Wilson, did you want the floor?

Mr J. Wilson: Just very quickly, Madam Chair, I do not have a clue what Mr Owens is talking about.

The Chair: We will call the question. Shall the amendment carry? All those in favour of the amendment? Any opposed?

Motion agreed to.

Section 6, as amended, agreed to.

L'article 6, modifié, est adopté.

Section 7 agreed to.

L'article 7 est adopté.

Section/article 8:

The Chair: Shall section 8 stand as part of the bill? All in favour? Any opposed?

Section 8 deleted.

L'articles 8 est rayé.

Sections 9 to 14, inclusive, deleted.

Les articles 9 à 14, inclusivement, sont rayés.

Section/article 15:

The Chair: Mr Wessenger moves that subsection 15(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

Motion agreed to.

The Chair: Mr Wessenger moves that the French version of subsection 15(1) of the bill be amended by striking out "technicien" in the second line and substituting "technologue."

And he further moves that the French version of subsection 15(3) of the bill be amended by striking out "technicien" in the fourth line and substituting "technologue."

Motion agreed to.

Section 15, as amended, agreed to.

L'article 15, modifié, est adopté.

Sections 16 and 17 agreed to.

Les articles 16 et 17 sont adoptés.

Section/article 18:

The Chair: Mr Wessenger moves that section 18 of the bill be amended by striking out "college" in the third line and substituting "council" and by striking out clause (b).

Motion agreed to.

The Chair: Mr Wessenger moves that section 18 of the bill be amended by adding the following subsection:

"(2) Subject to the approval of the Lieutenant Governor in Council, the minister may make regulations prescribing forms of energy, other than ionizing radiation, for the purposes of section 3."

Motion agreed to.

Section 18, as amended, agreed to.

L'article 18, modifié, est adopté.

Sections 19 to 21, inclusive, agreed to.

Les articles 19 à 21, inclusivement, sont adoptés.

Section/article 22:

The Chair: Mr Wessenger moves that section 22 of the bill be amended by adding the following subsection:

"(4) Despite subsection (1), section 81.1 of the health professions procedural code, as it applies in respect of this act, does not come into force until one year after this act comes into force."

Motion agreed to.

Section 22, as amended, agreed to.

L'article 22, modifié, est adopté.

Section/article 23:

The Chair: Mr Wessenger moves that the French version of section 23 of the bill be amended by striking out "techniciens" in the second line and substituting "technologues."

Motion agreed to.

Section 23, as amended, agreed to.

L'article 23, modifié, est adopté.

Title/titre:

The Chair: Mr Wessenger moves that the French version of the long title of the bill be amended by striking out "technicien" and substituting "technologue."

Motion agreed to.

Title agreed to.

Le titre est adopté.

The Chair: Shall the bill, as amended, carry? All those in favour? Any opposed? Carried.

The Chair: Are we ready for Bill 55?

Mr Wessenger: I think we should have a 10-minute adjournment.

The Chair: We have a request for a 10-minute recess. We will reconvene in 10 minutes.

The committee recessed at 1608.

1619

MEDICINE ACT, 1991

LOI DE 1991 SUR LES MÉDECINS

Sections 1 to 3, inclusive, agreed to.

Les articles 1 à 3, inclusivement, sont adoptés.

Section/article 4:

The Chair: Mr Wessenger moves that paragraph 1 of section 4 of the bill be struck out and the following substituted:

"1. Communicating a diagnosis identifying a disease or disorder as the cause of a person's symptoms."

Mr Wessenger: This amendment removes "dysfunction" from the authorized act re diagnosis.

Motion agreed to.

The Chair: Mr Wessenger moves that subparagraph ii of paragraph 6 of section 4 of the bill be struck out and the following substituted:

"ii. beyond the point in the nasal passages where they normally narrow."

Motion agreed to.

Section 4, as amended, agreed to.

L'article 4, modifié, est adopté.

Section 5 agreed to.

L'article 5 est adopté.

Section/article 6:

The Chair: Mr Wessenger moves that clause 6(1)(a) of the bill be struck out and the following substituted:

"(a) at least fifteen and no more than sixteen persons who are members elected in the prescribed number and manner";

And he further moves that clause 6(1)(b) of the bill be amended by striking out "nine" in the first line and substituting "at least thirteen and no more than fifteen."

Mr Wessenger: Again, this changes the council composition to increase the public members to just under half.

Mr J. Wilson: I note again that we will be voting against this. Particularly in light of the next amendment being put forward by myself, a vote in favour of this right now without considering the second amendment, if the second amendment were to pass, would throw off the government's composition.

The Chair: All those in favour of the amendment? Any opposed?

Motion agreed to.

The Chair: Mr J. Wilson moves that clause 6(1)(c) of the bill be struck out and the following substituted:

"(c) one person for each faculty of medicine of a university in Ontario selected in the prescribed manner from among members who are members of the faculty."

Mr J. Wilson: The purpose of this amendment is to retain the current representation of five academic appointments, one from each medical school, on the council of the College of Physicians and Surgeons of Ontario. It is some-

thing the council has very much asked for. If I may, I will read a backgrounder that has been provided by the CPSO.

"Over the years the academic appointees to the college council have offered a unique and valuable perspective on our activities. They are not elected by doctors and yet they represent a large and important component of the practice of medicine. They bring administrative, educational and professional expertise to the college. Their background is steeped in critical analysis and they often bring different views to college activities and decisions. They often have leadership qualities that serve the college well. They have experience in quality management and standards and understand administrative processes. They are more likely to be able to arrange the time to become involved in college activity. And furthermore, they are usually able to look ahead and consider innovative and creative roles for the college. This brings a sensible balance to the makeup of the college, exerting an influence that is congruent with the goals of government and society.

"The faculty representatives give the college ready access into the system of educating physicians and this system varies in each medical faculty. They provide feedback from the college directly to medical faculties and are often critical in effecting change in medical education."

"Most important, as the report of the Task Force on Sexual Abuse of Patients highlighted, many of the college's activities in the coming years will be focused on educational initiatives to help doctors address patients' and societal concerns more effectively. Without question, the college's faculty representatives are vital advocates for change in the education system. Losing some of these voices will mean losing some of the college's effectiveness in lobbying for and implementing educational change.

"Given these concerns, the CPSO asks that the committee consider this amendment."

Mr Wessenger: I would like to oppose the amendment. First of all, the College of Physicians and Surgeons of Ontario has more academic representation than other colleges. Second, adding two more academics would create a greater imbalance in the proportion of professionals on the council, since academic representatives are not treated as elected physicians in calculating the just-over-half.

We are not persuaded that three academics are not sufficient to provide an academic perspective, and there are other ways of ensuring that regional academic views are made known to the college such as consultation processes and also perhaps determining a method of rotation under the Medicine Act.

Mr McClelland: Our position, for the record, is that the point made by the member for the third party is very well taken. There is considerable difference from faculty to faculty. There is innovation in terms of the curriculum and the practicum, in terms of the education in the profession. Because of that diversity and because of the dynamic that this provides, we feel it is a well-reasoned and well-thought-out motion and we will be supporting the amendment as proposed by the third party.

Mr J. Wilson: I guess the college has a great deal of difficulty understanding why the government is forcing it

to chose from among its five faculties of medicine which ones will now sit on the CPSO. They do not understand thoroughly why the government has unilaterally decided to reduce that representation from five to three.

The Chair: Are we ready for the vote? All those in favour of the amendment? All those opposed? Carried.

Mr J. Wilson: Thank you very much.

The Chair: Mr Wilson, I think we are having a conference here with the parliamentary assistant. Mr Wessinger, did you have a—

Mr Wessinger: No.

The Chair: After saying you were going to speak against it.

Mr Wessinger: I am speaking against it and I am voting against it too.

The Chair: We have had a request to take the vote again.

Mr J. Wilson: Perhaps we can have a recorded vote.

The committee divided on Mr J. Wilson's motion, which was negated on the following vote:

Ayes-3

McClelland, Sola, Wilson, J.

Nays-6

Haeck, Hope, Malkowski, Martin, Owens, Wessinger.

Section 6, as amended, agreed to.

L'article 6, modifié, est adopté.

Section 7 agreed to.

L'article 7 est adopté.

Section/article 8:

The Chair: Shall section 8 stand as part of the bill? All in favour? Any opposed?

Section 8 deleted.

L'article 8 est rayé.

Sections 9 to 14, inclusive, deleted.

Les articles 8 à 14, inclusivement, sont rayés.

Section 15 agreed to.

L'article 15 est adopté.

Section/article 16:

The Chair: Mr Wessinger moves that subsection 16(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

Motion agreed to.

Section 16, as amended, agreed to.

L'article 16, modifié, est adopté.

1630

Section/article 17:

The Chair: Shall section 17 stand as part of the bill? All in favour? Any opposed?

Section 17 deleted.

L'article 17 est rayé.

The Chair: Mr McClelland moves that the bill be amended by adding the following section:

"17.1 In addition to the grounds set out in subsection 49(1) of the health professions procedural code, a panel of the discipline committee shall find that a member has committed an act of professional misconduct if the member has treated a person, in a situation in which a consent to treatment is required by law, without such a consent."

Mr McClelland: The amendment is essentially in response to submissions made by, among others, the psychiatric patient advocate office. The submissions were made to this committee on August 26 of this year. There has been significant concern raised by a variety of advocates on behalf of psychiatric patients that there is considerable disregard for the legal requirement of competent, informed consent from time to time and from place to place, particularly in provincial psychiatric hospitals. This situation could be worse in the absence of advocates who would on behalf of the patients press complaints on the law.

I will not get into the substance of it right now. There are other reasons in support of this that I think are known to the government members. I do not think we have to revisit the submissions that were made. I would ask you to refer to the submissions made on August 26, 1991. It is my understanding that the government has agreed to stand this matter down pending its consideration of the matter further.

The Chair: Do we have agreement to stand the section down? Do you want to speak to it now, Mr Wilson, or stand it down?

Mr J. Wilson: I agree with standing it down. I would ask, when it is reconsidered again, why this matter is not being dealt with under Bill 109, the Consent to Treatment Act.

The Chair: Then shall section 17.1 be stood down? Agreed. Shall we consider it at the next sitting of the committee, if possible? Agreed.

Sections 18 and 19 agreed to.

Les articles 18 et 19 sont adoptés.

Section/article 20:

The Chair: Mr Wessinger moves that section 20 of the bill be amended by striking out "college" in the third line and substituting "council" and by striking out clause (c).

Motion agreed to.

Section 20, as amended, agreed to.

L'article 20, modifié, est adopté.

Section 21 to 23, inclusive, agreed to.

Les articles 21 à 23, inclusivement, sont adoptés.

Section/article 24:

The Chair: Mr Wessinger moves that section 24 of the bill be amended by adding the following subsection:

"(4) Despite subsection (1), section 81.1 of the health professions procedural code, as it applies in respect of this act, does not come into force until one year after this act comes into force."

Motion agreed to.

Section 24, as amended, agreed to.

L'article 24, modifié, est adopté.

Section 25 agreed to.

L'article 25 est adopté.

Title agreed to.
Le titre est adopté.

The Chair: You will note that I am not calling the bill. We have an outstanding section. Hopefully, we will deal with it.

Mr Hope: I was just making sure you did not call it.

The Chair: I am glad you are checking up on me, Mr. Hope.

MIDWIFERY ACT, 1991

LOI DE 1991 SUR LES SAGES-FEMMES

Section 1 to 3, inclusive, agreed to.
Les articles 1 à 3, inclusivement, sont adoptés.

Section/article 4:

The Chair: Mr Wessenger moves that paragraph 3 of section 4 of the bill be struck out and the following substituted:

"3. Administering, by injection or inhalation, a substance designated in the regulations."

And he further moves that section 4 of the bill be amended by adding the following paragraphs:

"5. Taking blood samples from newborns by skin pricking or from women from veins or by skin pricking.

"6. Inserting urinary catheters into women.

"7. Prescribing drugs designated in the regulations."

Motion agreed to.

Section 4, as amended, agreed to.
L'article 4, modifié, est adopté.

Section 5 agreed to.
L'article 5 est adopté.

Section/article 6:

The Chair: Mr Wessenger moves that clause 6(1)(a) of the bill be amended by striking out "at least eight and no more than ten" in the first line and substituting "at least seven and no more than eight."

And he further moves that clause 6(1)(b) of the bill be amended by striking out "four or five" in the first line and substituting "at least five and no more than seven."

Mr J. Wilson: I have a question for the parliamentary assistant. How many new government appointments are coming into effect as a result of all the legislation regarding the Health Professions Regulation Act?

Mr Wessenger: There will be approximately 70 appointments as a result of all the legislation.

The Chair: All those in favour of the amendment? Those opposed?

Motion agreed to.

Section 6, as amended, agreed to.
L'article 6, modifié, est adopté.

Section 7 agreed to.
L'article 7 est adopté.

Section/article 8:

The Chair: Shall section 8 stand as part of the bill? All in favour? Any opposed?

Section 8 deleted.
L'article 8 est rayé.

Sections 9 to 14, inclusive, deleted.
Les articles 9 à 14, inclusivement, sont rayés.

Section/article 15:

The Chair: Mr Wessenger moves that subsection 15(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

Motion agreed to.

Section 15, as amended, agreed to.
L'article 15, modifié, est adopté.

Sections 16 and 17 agreed to.
Les articles 16 et 17 sont adoptés.

Section/article 18:

The Chair: Mr Wessenger moves that section 18 of the bill be amended by striking out "college" in the third line and substituting "council" and by striking out clause (c).

Motion agreed to.

1640

The Chair: Mr Wessenger moves that clause 18(a) of the bill be struck out and the following substituted:

"(a) designating the substances that may be administered by injection or inhalation and the drugs that may be prescribed by members in the course of engaging in the practice of midwifery."

Motion agreed to.

Section 18, as amended, agreed to.
L'article 18, modifié, est adopté.

Sections 19 and 20 agreed to.
Les articles 19 et 20 sont adoptés.

Section/article 21:

The Chair: Mr Wessenger moves that section 21 of the bill be amended by adding the following subsection:

(4) Despite subsection (1), section 81.1 of the health professions procedural code, as it applies in respect of this act, does not come into force until one year after this act comes into force."

Motion agreed to.

Section 21, as amended, agreed to.
L'article 21, modifié, est adopté.

Section 22 agreed to.
L'article 22 est adopté.

Title agreed to.
Le titre est adopté.

Mr Wessenger: Before we pass this bill, I would just like to make some comments with respect to the bill. First of all, I ask that the bill not be passed today, but that it be stood down until we have the opportunity to see what amendments might be required after consultations with respect to native groups. I would ask that we not vote on the bill today, that it be stood down until the same time as we consider Bill 43, if that might be accepted.

The Chair: That would be after Bill 64. I know there are some people here today with an interest in the bill who are keen to see it go forward. What we have done to this point in time is carry all the sections of the bill including

the title. The only thing that remains is for me to call the bill, as amended.

What the government has just informed the committee is that there may be some amendments regarding native midwifery. It does not know at this point in time whether there will be or not, so it has asked that the bill be held open or that we not conclude the bill until we have dealt with all the sections dealing with native issues as they relate to both Bill 43 and to this bill, Bill 56, and that this be dealt with following the completion of Bill 24 in the package. Is that clear to everyone?

Mr Hope: No problem.

The Chair: The bill will be reconsidered following completion of Bill 64, which could take place next week. Will the government be ready to proceed?

Mr Wessinger: We will not be ready to proceed until after October 30.

The Chair: We could schedule time now for the committee to meet on the first Monday following October 30—would the clerk note that, with the concurrence of the committee—for the conclusion of all items that relate to the native issues. For the interest of anyone in any of the

midwifery issues, any of the native issues, the committee will be dealing with that on November 4, following question period, at approximately 3:30 in the afternoon. There will be a formal notice of the meeting, but it looks to me like that is the date as of now.

We have completed the work before us today, but the committee has to decide. We have eight bills remaining.

Mr J. Wilson: My recommendation would be the following four bills on Monday, the following four bills next Tuesday, and on November 4, cleanup day, including dealing with native issues.

The Chair: Is it agreed? Agreed. If all members and caucuses could have any outstanding or proposed amendments to the clerk by this Friday, that would be appreciated. The plan is that we will deal with the next four bills next Monday, and the last four bills next Tuesday, with the anticipation that we should be able to complete the bills. However, we have established November 4 as the date to complete any of the outstanding items and most particularly the native issues as they relate to this package of legislation.

The committee adjourned at 1646.

CONTENTS

Tuesday 22 October 1991

Regulated Health Professions Act, 1991, and companion legislation / Loi de 1991 sur les professions de la santé réglementées et les projets de loi qui l'accompagnent	S-887
Medical Laboratory Technology Act, 1991 / Loi de 1991 sur les techniciens de laboratoire médical	S-887
Medical Radiation Technology Act, 1991 / Loi de 1991 sur les techniciens en radiation médicale	S-889
Medicine Act, 1991 / Loi de 1991 sur les médecins	S-891
Midwifery Act, 1991 / Loi de 1991 sur les sages-femmes	S-893

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First Session, 35th Parliament

Official Report of Debates (Hansard)

Monday 28 October 1991

Standing committee on social development

Regulated Health
Professions Act, 1991
and companion legislation

Assemblée législative de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le lundi 28 octobre 1991

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent



Chair: Elinor Caplan
Clerk: Lynn Mellor

Présidente : Elinor Caplan
Greffière : Lynn Mellor

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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 28 October 1991

The committee met at 1533 in room 151.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Suite de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

NURSING ACT, 1991

LOI DE 1991 SUR LES INFIRMIÈRES ET INFIRMIERS

The Chair: I will follow the McCague rule. Apparently former member George McCague, at the appointed hour for starting many meetings, used to look around the room, and even if there was no one there used to say, "I see a quorum," and begin the meeting.

Interjection.

The Chair: I thought you might find that interesting, Mr Wilson. I see a quorum. The standing committee on social development is now in session. We are proceeding today with Bill 57, An Act respecting the regulation of the Profession of Nursing. We will begin, as we have, in calling the clauses of the bill.

Sections 1 and 2 agreed to.

Les articles 1 et 2 sont adoptés.

Section/article 3:

The Chair: Mr Beer moves that section 3 of the bill be amended by inserting after "the practice of nursing is" in the first line "the promotion of health and."

Mr Beer: Just briefly, the purpose of this is that a number of the witnesses had said they believed part of the practice of nursing was the promotion of health and we wanted to underline that and for that reason have added those words.

Mr J. Wilson: I know the Liberal amendment is exactly the same as the Progressive Conservative amendment on the next page. I just indicate that we also propose the inclusion of "promotion of health" and are supportive of it. Health promotion is a widely-used nursing intervention strategy that is supported by extensive literature. It is formally taught to all nursing students across the province, thus making nurses qualified to include health promotion in their practice.

Mr Wessinger: We will be supporting the amendment. Certainly nurses play a very strong role in the promotion of health, particularly the public health nurses. Also, I do not think this in any way diminishes the fact that

we should recognize every other profession that also contributes to the promotion of health.

The Chair: Mr Wilson, did you wish to withdraw your amendment?

Mr J. Wilson: Yes.

Motion agreed to.

Section 3, as amended, agreed to.
L'article 3, modifié, est adopté.

Section/article 4:

The Chair: Mr Wessinger moves that subsection 4(1) of the bill be amended by striking out "on the order of a qualified person" in the third and fourth lines of paragraph 1, in the second and third lines of paragraph 2 and the second line of paragraph 3.

And he further moves that subsection 4(2) of the bill be struck out.

Mr Wessinger: This is related to the fact that with the other bills we are removing "on the order of" and it also is related to a subsequent amendment that we will be making with respect to section 4.1.

Mr Beer: We will be supporting this amendment and reserving comment on a further amendment that will be coming later.

The Chair: You also have a motion to section 4 that is identical.

Mr Beer: Yes and we would remove that.

The Chair: You withdraw it. Further discussion?

Mr J. Wilson: I would also like to say that we are pleased to support this amendment. We would have brought forward our own amendment had the government not already done so in this area. We do not believe that the words "on the order of" adequately reflect the realities in the nursing profession. I would point out though, as I did in the Legislature this afternoon—we will deal with a more specific amendment in a few minutes, that it is ironic that the government is, in this case, removing "on the order of," but is now requiring nurses to take orders from midwives and chiroprodists.

Motion agreed to.

The Chair: Mr Wessinger moves that subparagraph 4(1)(3)ii of the bill be struck out and the following substituted:

"ii. beyond the point in the nasal passages where they normally narrow."

Motion agreed to.

Section 4, as amended, agreed to.
L'article 4, modifié, est adopté.

The Chair: Mr Wessinger moves that the bill be amended by adding the following section:

"4.1(1) A member shall not perform a procedure under the authority of subsection 4(1) unless,

"(a) the performance of the procedure by the member is permitted by the regulations and the member performs the procedure in accordance with the regulations; or

"(b) the procedure is ordered by a person who is authorized by the Chiropractic Act, 1991, Dentistry Act, 1991, Medicine Act, 1991 or Midwifery Act, 1991 to do the procedure.

1540

"(2) In addition to the grounds set out in subsection 49(1) of the health professions procedural code, a panel of the discipline committee shall find that a member has committed an act of professional misconduct if the member contravenes subsection (1)."

Mr Wessinger: The purpose of this amendment is that because of the change in section 4 removing "qualified person" it is necessary to designate under what acts the persons who can make the orders are. "Qualified persons" were under the Chiropractic Act, the Dentistry Act, the Medicine Act or the Midwifery Act. In effect, that aspect does not change the act at all. It is exactly the same as it was under the previous act. This also permits the regulations to be passed by the college to authorize the procedures by members.

The Chair: Mr Wilson, I ask that you let me know what you want to do with your amendment.

Mr J. Wilson: I think I should move my amendment to the government's amendment at this point.

The Chair: Mr J. Wilson moves that the motion to add section 4.1 to the bill be amended by striking out clause 4.1(1)(b) as set out in the motion and substituting the following:

"(b) the procedure is ordered by a person who is authorized by the Dentistry Act, 1991 or Medicine Act, 1991 to do the procedure."

Mr J. Wilson: We believe that clause (b) of the government amendment will mean, in practical terms, that nurses will have to take orders from midwives and chiropractors. We do not feel that nurses should have to take orders from midwives in particular. There was compelling evidence before this committee and a real disdain from nurses before this committee that the hierarchy in health care would continue to be reinforced and in fact promoted by this government now that nurses, who receive far superior training to date than midwives, would be required to take orders from midwives and chiropractors adding yet two more levels to the hierarchy.

For that reason, I ask the parliamentary assistant how the government can justify promoting the health care hierarchy when this whole legislation has been sold to the public as a means of down playing the current hierarchy that exists.

Mr Wessinger: The purpose of this act is not to create a hierarchy and the purpose of this amendment is not to create a hierarchy. The purpose of this amendment is to allow health professionals to work together. What the amendment means is that orders written for patients by chiropractors and midwives can be implemented by nurses. If the Conservative amendment was accepted, orders writ-

ten for patients by a chiropractor or a midwife could not be implemented by a nurse. In effect, the nurses would not be able to work with either chiropractors or midwives.

That would create a difficulty in the whole question of delivery of health care and create great inflexibility in it. We have to know that both chiropractors and midwives are authorized, under their respective acts, to prescribe drugs and to administer substances by injection. In many instances, the chiropractor or the midwife may not be available to administer the substance and it would be necessary for a nurse to be present to carry out that act. For the benefit of the whole health care system, it is important that nurses be authorized to carry out those orders. Otherwise we are putting rigidity into the health care system.

If the Conservative amendment was accepted, it would interfere with hospital-based and community-based care. It certainly would not be in the patient's interest and it would also interfere with employment opportunities not only for midwives and chiropractors, but also for nurses.

The Chair: We will keep our remarks directed to Mr Wilson's amendment of the amendment at this time.

Mr Beer: Because they have both been presented, I have a couple of comments that I want to make about them. We reject both and feel they are very much against the spirit of what we were discussing when we made a change to the scope of practice. What we really need to look at is the fundamental principle I believe we accepted when we made the change in the scope of practice, which is that they are all of a certain equality—the profession of nursing along with the others—and the issue raised by this amendment is one the colleges themselves can sort out. There is no need for this, and in fact it creates a continuing dependence of nurses doing things only through the orders of other professions.

It seemed clear to me that what we were trying to do in the original legislation was to make clear how this would work, not just among the nurses and the other organizations mentioned here, but broadly speaking, among the different groups of health care professionals. There would be a number of procedural matters to resolve, and we should leave the colleges to sort out how that is going to be done.

The other thing I find somewhat disturbing, and I raised this with the parliamentary assistant, is that the government amendment was made known to the Ontario Nursing Association, but not to either the college or the Registered Nurses' Association of Ontario until very recently, perhaps just within the last few days. Coming at this time, it seems to me it sends a message that what we have done in effect is to say that while we are taking it out of the scope of practice—that you do not do these things on the authorization of these other professions—we are putting it back in through another door.

I am not convinced by the arguments of the parliamentary assistant, and say quite frankly to my colleague from the Conservative Party that I do not understand why we need either amendment. I suggest that both be rejected and that the wording presently found in the act be left as it is. Whether speaking to the amendment to the government

motion or to the government motion itself, we do not feel that this makes sense. Indeed, we feel it goes quite counter to the spirit of the legislation as amended up to this point.

Mr J. Wilson: I would say to Mr Beer that it is unrealistic to try and change the government's motion, since we know the way this committee operates. The government's motion is going to go through, so I am simply attempting with an amendment to improve the government's motion, as we know it is a fait accompli. It is unrealistic to argue that neither of these amendments should be here, since the government did put one forward and we all know how they are going to vote. I agree with much of what you said, but I think you can figure out the parts of your remarks that I do not agree with.

The Chair: Any further debate on Mr Wilson's amendment to the amendment? All those in favour? Those opposed?

Motion negatived.

Mr Wessinger: I would like to comment on the comments of Mr Beer concerning our amendment.

First, it should be clear that clause 4(a) sets out that the nurses are authorized. The performance of a procedure by the member is permitted by the regulations, and the member performs a procedure in accordance with the regulations. In effect, the college is setting out what authority nurses have to perform acts and it can pass appropriate regulations. It is within its own authority, through the regulatory power, to determine what authority nurses have. To say the college does not have that power is incorrect. It does have that power. It is something that gives the college expanded authority, which I am sure it uses very responsibly.

I would also indicate that there was consultation with both organizations, the college and the professional association, with respect to this amendment. Certainly there was no problem with the amendment as it related to the authority provided under the regulations. We understand it was very acceptable to the groups.

1550

Mr Owens: I have a question around the area of grounds for misconduct. Could the parliamentary assistant explain to the committee how subsection 2 applies, and how this amendment is seen only as an avenue for nurses to participate in health care, with the expanded scope that has been given? Second, how does subsection 2 get around the issue of standing orders not being signed retroactively that nurses raised during the hearings?

Mr Wessinger: I will call on counsel to answer that question.

Ms Bohnen: Prior to the amendment that appears in subsection 2, if a nurse performed an authorized act that had not been ordered she was liable to be prosecuted. This amendment, with the restructuring together with subsection 2, makes it clear that she cannot be prosecuted if she acts in the absence of an order that is necessary. She could only be held to account for what she did by her own college and that change, as I understand it, is viewed very positively by all nursing organizations.

With respect to how it relates to standing orders and the retroactivity, it does not do so directly. Standing orders

and protocols will likely still exist in the health care system, at least for some time, and would fall within the authority granted in 4.1(1)(b). But since the nurse's only liability, so to speak, would be to her own college, I think we could expect the college to take into account the difficulty the nurse was placed in in operating under the authority of a standing order, with perhaps greater sympathy than a court might have if the nurse had been prosecuted.

Mr Beer: If all those organizations were consulted, I accept what the parliamentary assistant has said. I was informed that consultation had not been as set out. However, that being said, I want to underline again that we believe very strongly that this amendment moved by the government goes very much against the spirit of what we are trying to do. It is not necessary, and for that reason we will be opposing it.

Mr Martin: I understand where Mr Beer is coming from on this. If in fact it is against the spirit of levelling out the health profession field in terms of who can do what and creating more of a team approach to the delivery of medicine, I would like to hear somebody from counsel or the ministry speak to that for a minute.

Mr Wessinger: I would like counsel to speak to that, as per your request, Mr Martin.

Ms Bohnen: The health care system certainly will be enhanced by teamwork and the government believes that better teamwork will result from it. Better teamwork also depends on the members of the team knowing what their authority is. Right now, under the Health Disciplines Act, the scope of practice of nursing is not even defined or described, and in practice in hospitals and in the community, nurses have very little clearly defined authority to act without a medical order.

These amendments and the earlier amendments not only clarify what the scope of practice of nursing is, but provide an ongoing mechanism for nursing to say nurses decide for themselves to do the following, A, B, C or D, whatever it may be that nursing determines nurses do on their own authority. That will be clear to nurses, who need the clarity to know how to operate in the settings in which they work; it will be clear to hospitals and community agencies that employ them, and it will be clear to other members of the team. Doing it in the way the government has proposed also provides safeguards so that the government and the public, through the advisory council and its review of the Nursing Act regulations, know that patient care is going to be advanced by the regulations made by the college of nurses and that patient safety and the wellbeing of patients is enhanced by it.

I think the government's position is that in principle it absolutely agrees with what Mr Beer has been saying. The issue has come down to, should the act be silent on what things nurses do on their own authority or should this proposed mechanism be put in so that it can be defined in the regulations?

Mr Martin: To help me understand this a bit, what you are saying then is that in many instances nurses operate autonomously and do what they are trained to do, but there are some instances in which, perhaps because of the

seriousness of the act or the situation, somebody has to decide what needs to be done and in that instance it is somebody who has a specialization in that particular area. Is that what you are saying to me?

Ms Bohnen: First of all, remember we are only talking about authority to perform things that are controlled acts. Much of the scope of practice of nursing is not controlled by the controlled acts in any way. Nurses do those things on their own authority, but there are hazardous things for which orders must be written for the patient, and the question is, who should write those orders? When you say that a member of a particular profession should write the order or should be able to write the order, what you are really saying is that a member of a particular profession has the qualifications, the experience and so on to make treatment decisions about the patient.

This legislation recognizes that nurses are qualified to make certain treatment decisions but not all treatment decisions, that some are sufficiently hazardous that they ought to be made by a physician, a dentist, a midwife or a chiropractor because of their more specialized training in the area, but that, yes, there are things that nurses are qualified to make treatment decisions about. Paragraph (a) of the amendment authorizes the college of nurses to determine, in the way the system has those determinations made, what those things are.

Mr Martin: I have just one more question for the parliamentary assistant. In your initial comments you said that this gives the midwife permission to do certain things. I am wondering why that would not have been included in the Midwifery Act.

Mr Wessinger: I think what I referred to is the fact that midwives are authorized under their act to prescribe drugs and to administer substances by injection. That is part of their authorized acts. They can write an order for a patient, and then a nurse might administer that substance, might follow that patient order, just like a doctor might do the same type of order.

Mr Beer: We want to remember what it is we are trying to do. In terms of where the act is silent or not silent and what ought to be in the act or not in the act, fundamentally we are still creating a college of nurses which I believe is going to operate and act and make decisions in an appropriate and responsible way. In doing that and in working out how they do that, they will have to take heed of other colleges and other professions that are active. I have no problem in that context with clause 4.1(1)(a), which seems to me clearly one of the things the college of nurses will do, but I believe that (b) is inappropriate in the legislation, that this is something which is more appropriately dealt with by the colleges in working out how this will take place. It does insert a certain hierarchy, which may not be intended but none the less is there, as to where nurses fit into the scheme of things.

1600

With this legislation we are clearly establishing some new norms, some new directions, some new ways in which we are in effect going to require colleges to work together, one with the other. I simply read clause (b) as a

step backwards. In a very real sense it appears that what one has taken out from the scope of practice with one hand, one has put back in through the back door. While I understand the practical arguments around how the various professions ought to work together, I believe that can be sorted out in a way that does not require a specific legislative act. Because of clause (b), I just do not believe we can support this amendment.

Mr J. Wilson: Those comments ignore the fact that nurses already are under a hierarchy in that they have to take orders from dentists and medical doctors. I will be voting against the government amendment, as I have already made clear, because we very strongly feel that the government, contrary to what it has said publicly time and time again to nursing associations, is again reinforcing this hierarchy by dictating that nurses now will take orders from midwives and chiropractors. We are going from bad to worse.

Ms Haack: I would have to disagree with my honourable colleague Mr Wilson.

Mr J. Wilson: At least we got "honourable" today.

Ms Haack: It is more than that. In fact, you have been an extremely active member of this committee and I feel that you have had a lot of good things to say. However, I think there is another side to this. That is the side of the midwives. Thinking about all the discussion we have heard, be it here in Toronto or on the road, I feel that having it written here in this part of the legislation reinforces and supports a very strong concern on the part of the midwives that they be allowed to practise in hospital as part of the nursing team, which I do not feel would necessarily happen if it was strictly left to the college.

It behooves us as legislators to have it clearly outlined that midwives are part of the health care team. They are going to be able to follow their patients from their home into hospital and practise appropriately within the hospital setting. I think it is an extremely important portion of this piece of legislation to make sure it is here and is supportive of a very new, innovative procedure that does not exist at the present time.

Mr Beer: I would like to make very clear that I am not arguing that midwives and nurses, or chiropractors and nurses, should not work co-operatively together. As we have done in supporting the Midwifery Act, we see them as a very important new part of the whole area of the health care professions, but what is still a key element to recognize is how we do that. To do that, I do not believe having this part in the act is necessary, and I believe it sends out a variety of other messages about the place of nursing. I think we need to deal with that through the colleges.

The Chair: Further debate on the amendment? All those in favour of the amendment? Those opposed?

Motion agreed to.

Sections 5 and 6 agreed to.

Les articles 5 et 6 sont adoptés.

Section/article 7:

Mr J. Wilson: Perhaps I may make a comment on section 7 on behalf of registered nursing assistants, or practical nurses as they are referred to in section 7 and the

remainder of the act. We certainly believe registered nursing assistants should have their own college. We share the disappointment of registered nursing assistants that the government did not bring forward a profession-specific act for RNAs.

This is just to point out that Ontario remains the only province where RNs and RNAs register with the same board. Many RNAs are unhappy about being regulated with RNs by the College of Nurses of Ontario. Twice in the past eight years, the Ontario Association of Registered Nursing Assistants has surveyed its membership and found that over 90% of those who responded favoured separation. One of the main reasons for RNAs' dissatisfaction is that their profession is outnumbered two to one by RNs on the present council, which is section 8 of the act.

I would like to ask that this matter be referred to the advisory council. I would also like some sort of guarantee from the parliamentary assistant at this time that this matter will be looked at in a timely manner.

Mr Owens: I would like to suggest to the member of the third party that it is my understanding the government has referred this issue, or will refer this issue, to the advisory council for determination as to whether the two nursing groups should be divided. It is the feeling that there is clearly enough evidence pointing to the fact that there are differences, that there are problems with respect to their current association, and that an investigation should take place with a view to perhaps separating the two groups into two separate colleges. That has been done or will be done, and if there is any clarification on the matter, I ask the parliamentary assistant to correct or add to the record.

Mr Wessinger: Yes, I would like to confirm that. In my opening statement, I indicated the matter would be referred to the advisory council, so it is clearly on record that this matter will be dealt with.

Mr J. Wilson: Do we have a time frame for that?

Mr Wessinger: I understand the intention is to set up the advisory council. That is the first aspect of this legislation, so it will be operating first and we can deal with the matter before the rest of the bill is implemented.

Mr Beer: I think this is an issue where there is agreement. Indeed, in the nursing assistants' presentation, they asked that this be done. I am certainly glad to see it is going to happen. I agree with my colleague from the Conservative Party that in these things we need to ensure there is a time frame that is going to be reasonably quick so that this can get resolved.

Mr Hope: As the RNs and RNAs indicated, there is also another health care provider out there called the health care aide, who has a very important role in our community settings and with our nursing homes. I hope that through the advisory committee, they will also look at individuals who work in that profession, making sure the determination is there. I feel confident that among them, those professionals on the advisory committee will be able to come up with a good standard, providing for the people of Ontario.

Section 7 agreed to.
L'article 7 est adopté.

1610

Section/article 8:

The Chair: Mr Wessinger moves that clause 8(1)(a) of the bill be struck out and the following substituted:

"(a) Twenty-one persons who are members elected in the prescribed manner, fourteen from among members who are registered nurses and seven from among members who are practical nurses."

And he further moves that clause 8(1)(b) of the bill be amended by striking out "eleven" in the first line and substituting "eighteen."

Mr J. Wilson: I would not want a week to go by without commenting on the section 8s—nothing to do with the MASH show, I am sure. I will be voting against this amendment. Members will recall that I put forward an amendment earlier dealing with Bill 43 that said that rather than having just under 50% lay representation on the councils, our party felt a more responsible approach would be a 60-40 split, with 60% professionals and 40% members of the public. We are very concerned about and want to make an earnest attempt to preserve the principle of self-regulation.

The Chair: All those in favour of the amendment? Any opposed?

Motion agreed to.

Section 8, as amended, agreed to.

L'article 8, modifié, est adopté.

Section 9 agreed to.

L'article 9 est adopté.

Section/article 10:

The Chair: Shall section 10 stand as part of the bill? All those in favour? Those opposed?

Section 10 deleted.

L'article 10 est rayé.

Sections 11 to 16, inclusive, deleted.

Les articles 11 à 16, inclusivement, sont rayés.

Section/article 17:

The Chair: Mr Wessinger moves that subsection 17(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

Motion agreed to.

The Chair: Mr Wessinger moves that subsection 17(2) of the bill be amended by striking out "dental nurse" in the third line.

Mr Wessinger: I believe this was requested. It removes an exception for dental nurses with respect to title protection.

Mr J. Wilson: Could we have a further explanation?

Mr Wessinger: I will have counsel explain this.

Ms Bohnen: You may recall we heard from the Ontario Dental Nurses and Assistants Association, an association of individuals who work as chairside assistants for dentists in their offices. They are not registered nurses or registered nursing assistants. Some time in the past they

used the title "dental nurse" but now they use the title "dental assistant." It was in the public interest not to permit these dental assistants to continue to use the term "dental nurse" because it is confusing to the public who might reasonably believe that they are registered nurses with dental qualifications. Since the association did not object to the deletion of this exception for their members, it seemed like an appropriate amendment.

Mr J. Wilson: If we remove "dental nurse" from the section, you are saying there is no objection whatsoever, and there is no longer any need to protect the term "dental nurse"?

Ms Bohnen: That is correct.

Mr J. Wilson: Okay. I have it straight.

Motion agreed to.

The Chair: Mr Wessenger moves that subsection 17(6) of the bill be amended by striking out "dental nurse" in the last line.

Motion agreed to.

Section 17, as amended, agreed to.

L'article 17, modifié, est adopté.

Sections 18 and 19 agreed to.

Les articles 18 et 19 sont adoptés.

Section/article 20:

The Chair: Mr Wessenger moves that section 20 of the bill be amended by striking out "college" in the third line and substituting "council" and by striking out clause (a).

Motion agreed to.

The Chair: Mr Wessenger moves that clause 20(c) of the bill be struck out and the following substituted:

"(c) permitting a member to perform a procedure under clause 4.1(1)(a) and governing the performance of the procedure including, without limiting the foregoing, prescribing the class of members that can perform the procedure and providing that the procedure may only be performed under the authority of a prescribed member or a member in a prescribed class."

Mr Wessenger: This relates to the prior amendment we passed providing for the passing of regulations to set out who may perform certain procedures. It sets out in more detail the aspect that they can prescribe that certain classes of members may perform certain procedures.

Mr Beer: I am afraid this is one where, in reading it, it is not terribly clear. Could the parliamentary assistant lead us through this? Dare I ask for an example? What is going on here? Who is doing what to whom and why?

Mr Wessenger: I may have to ask counsel to advise me, but my understanding is that, certainly within the nursing profession, there are sometimes special courses that can be taken by nurses that would give special qualifications. Therefore, under the act you could prescribe that people who had taken certain courses would have the authority to perform certain specific procedures. What is happening in nursing is that there is a wide variety of training in the nursing profession. I know that very highly specialized types of nurses even now perform work that

was formerly done by medical residents, and of course the whole idea is to expand the scope of practice for the nursing profession.

Mr Beer: In effect this deals, at least in part, with some nurses who would have particularly specialized training. They would be allowed to do certain things that, let's say, a regular nurse would not. Is that, in simple terms, what this is about?

Mr Wessenger: That is correct. In addition, it allows a distinction between the role of the practical nurse and the registered nurse.

Mr J. Wilson: I think it essentially says, if I understand it, that regulations will be set for certain procedures and this gives the legislative authority for setting out who actually will perform the procedure as set out in the regulation, which class of nurse.

Mr Wessenger: I may ask counsel to add something here.

Ms Bohnen: Basically that is what it does. The opening words simply give the college of nurses the authority to make regulations that might list those procedures that nurses are authorized to perform on their own authority. The rest of the words just go on to give examples of some of the issues these regulations might also address, such as, is it all nurses who can authorize them or some special class of nurses? It also makes it clear that the regulation could permit, say, an RN to make an order that could then be implemented by a practical nurse. It gives examples of the nature of the regulation-making authority to be exercised by the college.

Mr J. Wilson: Just for the record, I did not have any problem with clause 4.1(1)(a) of the government's earlier amendment to section 4.1; it was clause 4.1(1)(b) that we had a problem with when it referred to having orders taken from midwives or chiropractors. I do not have any particular problem with this amendment either and we will be supporting the amendment.

Motion agreed to.

Section 20, as amended, agreed to.

L'article 20, modifié, est adopté.

Sections 21 to 23, inclusive, agreed to.

Les articles 21 à 23, inclusivement, sont adoptés.

1620

Section/article 24:

The Chair: Mr Wessenger moves that section 24 of the bill be amended by adding the following subsection:

"(4) Despite subsection (1), section 81.1 of the health professions procedural code, as it applies in respect of this act, does not come into force until one year after this act comes into force."

Mr J. Wilson: I will be opposing this amendment because it relates to the patient relations program. In earlier debate last week we made the point that we believe the patient relations program does not include real help for victims and is therefore incomplete. Therefore I will be voting against this amendment.

The Chair: All those in favour of the amendment? Any opposed?

Motion agreed to.

The Chair: Shall section 24, as amended, carry?

Mr Beer: Before we do that, not to argue against section 24, I have a question. I was not quite sure of the appropriate place to raise it, so I decided I would raise it here and you can determine how we ought to handle this.

The question is with respect to the French title and some of the French-language phraseology in the act. We are talking about An Act respecting the regulation of the Profession of Nursing; the French title is *Loi concernant la réglementation de la profession d'infirmière ou d'infirmier*. It specifies, in French, both the feminine and masculine.

In other bills we have not necessarily used both the male and female modifier. I raise it here simply because I am not quite sure whether we ought to have it in those other bills. Throughout this, and I notice back in section 17, we were quite clear in talking about "infirmier" and "infirmière." It may be unfair to ask the parliamentary assistant for a linguistic ruling, but I raise it as a question as to whether there is any particular problem with those acts that only use the one and not both.

The Chair: The appropriate time for this discussion is when I call, "Shall the title carry?"

Section 24, as amended, agreed to.

L'article 24, modifié, est adopté.

Section 25 agreed to.

L'article 25 est adopté.

Title/titre:

The Chair: We have a question. Mr Wessenger.

Mr Wessenger: I refer that to the legislative counsel. I think he is the person who might be able to give us some guidance in that area.

Mr Spakowski: I am not a bilingual legislative counsel. We can certainly have someone available to answer it if you need the answer in more detail than I can provide. I know some of the issues that arose around the question of how to deal with the nursing title. My understanding is that the French feminine form has been used traditionally.

Normally in French the masculine for things like professions is used as the neutral or generic word. For nursing, the feminine form was used so the masculine form of "infirmière" could not carry its generic function. It did not sound right. Unfortunately, grammatically, the feminine form cannot be used as a generic so it was felt that the appropriate way to deal with it was to use both the masculine and the feminine form.

Mr Beer: I do not want to get into an extended debate over this and it risks getting into a whole series of gender-related observations. What you explain may be the way this has been done in the past, but I leave that as a question which perhaps legislative counsel might raise with other colleagues. For example, in Bills 48, 59 and 61, the masculine is used. It may be that for consistency as well as for other reasons we should be using both. If it is felt that here for some reason one will not do and you need both, then I

suggest you probably need the same in others. I simply leave that as a question because it struck me in the way this particular bill has been done.

The Chair: Are you requesting we hold this down so there can be that discussion?

Mr Beer: No, we do not have to hold it over, because I think it is quite correct, but it raises the question and I simply would like to get a clearer response on it.

The Chair: It might be appropriate if that question were responded to on November 5. We had reserved that time for any others. I would point out that we would have to reopen the other bills to deal with the title, but I think it would be appropriate to have a response from legislative counsel at that time.

Mr Spakowski: This is a topic we have fought long and hard on, and perhaps the best is to have a bilingual legislative counsel available, or someone from our French side of the office to explain more fully how we did what we did.

The Chair: Could they be here on September 5?

Mr Spakowski: Yes.

Title agreed to.

Le titre est adopté.

The Chair: Shall the bill, as amended, carry? All those in favour? Any opposed? Carried.

OCCUPATIONAL THERAPY ACT, 1991 LOI DE 1991 SUR LES ERGOTHÉRAPEUTES

The Chair: We have some observers here this afternoon whom I would like to point out and acknowledge and welcome. A delegation of federal representatives is here looking not only at the committee process, but at the televising of the committee. I hope we can prove helpful as you decide how to televise committee hearings on the Hill.

Sections 1 to 3, inclusive, agreed to.

Les articles 1 à 3, inclusivement, sont adoptés.

The Chair: Mr J. Wilson moves that the bill be amended by adding the following section:

"3.1 In the course of engaging in the practice of occupational therapy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to communicate a diagnosis within the scope of practice of occupational therapy."

Mr J. Wilson: We believe that occupational therapists should be able to communicate a diagnosis within their scope of practice, and we believe there is compelling evidence before this committee that they should be allowed to do so. The current practice of occupational therapy includes direct communication to their clients about diagnosis. Presentations before the committee showed how this communication is inherent in treatment planning and patient education. The Ontario Society of Occupational Therapists remains unconvinced that paragraph 26(2)1 of Bill 43 will not restrict treatment planning and patient education, so I would ask for members' support on this amendment.

Mr Wessenger: I will be speaking against this amendment, as I have spoken against the previous amendments

in other acts, because we believe that occupational therapists perform assessments and not diagnosis.

The Chair: All those in favour of the amendment? Any opposed?

Motion negated.

Section 4 agreed to.

L'article 4 est adopté.

Section/article 5:

The Chair: Mr Wessenger moves that clause 5(1)(a) of the bill be amended by striking out "at least seven and no more than ten" in the first line and substituting "at least six and no more than nine."

And he further moves that clause 5(1)(b) of the bill be amended by striking out "at least four and no more than six" in the first line and substituting "at least five and no more than seven."

The Chair: All those in favour of the amendment? Any opposed?

Motion agreed to.

Section 5, as amended, agreed to.

L'article 5, modifié, est adopté.

1630

Section 6 agreed to.

L'article 6 est adopté.

Section/article 7:

The Chair: Shall section 7 stand as part of the bill? All those in favour? Any opposed?

Section 7 deleted.

L'article 7 est rayé.

Sections 8 to 13, inclusive, deleted.

Les articles 8 à 13, inclusivement, sont rayés.

Section/article 14:

The Chair: Mr Wessenger moves that subsection 14(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

Motion agreed to.

The Chair: Mr Beer moves that subsection 14(1) of the bill be amended by striking out "No person other than a member" in the first line and the following substituted:

"All practising occupational therapists in Ontario shall use the title 'occupational therapist,' a variation or abbreviation or an equivalent in another language in the course of providing or offering to provide, service in Ontario."

Mr Beer: I believe one of the points raised was to make clear the use of OT as an abbreviation.

Mr Wessenger: I have some difficulty understanding the purpose of the amendment because I find the amendment would prohibit non-members from using the title "occupation therapist." If it does not prohibit it, it requires that the title be used, rather than prohibiting non-members from using the term. It takes away from the title protection as far as I see. I do not understand why we would want to take away the title protection from occupational therapists, unless I am missing something.

Mr Beer: If you have been missing something, I have been missing something as well. The concern that was raised was about the use of OT, which I gather is commonly used. There was concern expressed in the submissions that others could use that. If what you have suggested captures that, I would be prepared to withdraw it.

Mr Wessenger: In our opinion, certainly—

Mr Beer: I have great respect for your opinion.

Mr Wessenger: My opinion is that the abbreviation is covered, so OT is covered; it would be protected.

Mr Beer: That and 10 cents will get you a cup of coffee.

The Chair: Mr Beer, as I understand it, what you have requested from the parliamentary assistant is clarification that the legislation would not permit, or would permit the use of OT? By whom?

Mr Beer: The legislation would not permit the use of OT by people who are not authorized to be called occupational therapists.

Mr Wessenger: That is correct; it would not permit the use of OT.

The Chair: And with that clarification you are withdrawing your amendment?

Mr Beer: I am.

The Chair: Then it is withdrawn. Mr Wilson?

Mr J. Wilson: That is fine, Madam Chair.

Section 14, as amended, agreed to.

L'article 14, modifié, est adopté.

Sections 15 and 16 agreed to.

Les articles 15 et 16 sont adoptés.

Section/article 17:

The Chair: Mr Wessenger moves that section 17 of the bill be amended by striking out "college" in the third line and substituting "council" and by striking out clause (b).

Motion agreed to.

Section 17, as amended, agreed to.

L'article 17, modifié, est adopté.

Sections 18 and 19 agreed to.

Les articles 18 et 19 sont adoptés.

Section/article 20:

The Chair: Mr Wessenger moves that section 20 of the bill be amended by adding the following subsection:

"(4) Despite subsection (1), section 81.1 of the health professions procedural code, as it applies in respect of this act, does not come into force until one year after this act comes into force."

Motion agreed to.

Section 20, as amended, agreed to.

L'article 20, modifié, est adopté.

Section 21 agreed to.

L'article 21 est adopté.

Title agreed to.

Le titre est adopté.

The Chair: Shall the bill, as amended, carry? All those in favour? Any opposed? Carried.

OPTICIANRY ACT, 1991
LOI DE 1991 SUR LES OPTICIENS

Sections 1 and 2 agreed to.

Les articles 1 et 2 sont adoptés.

Section/article 3:

The Chair: Mr Wessenger moves that section 3 of the bill be amended by striking out "upon the prescription of an optometrist or physician" in the last two lines.

The Chair: Actually, there is a second one. They are identical. It is my understanding they are placed in order of when they have been received. I am assuming, Mr Beer, that should the government's motion carry, you will be withdrawing yours.

Mr Beer: I think that would be a good assumption to make, and I would so do.

Simply put, we feel, for the reasons that have been advanced, that this is a change we wanted to make. It was agreed to by those who have spoken to it and simply reflects that.

Mr J. Wilson: Is it my understanding that if this amendment were to pass, we would no longer be prescribing eyeglasses through opticians?

Mr Wessenger: No, that is not the case. It just changes the scope of practice statement; it does not change the aspect—

Mr J. Wilson: Well, why are we doing it?

Mr Wessenger: Because we have been doing it in all the acts, if I remember correctly.

Mr J. Wilson: You have taken out "on the order of."

Mr Wessenger: Yes, in all the acts. We have taken out "on the order of" or "upon the prescription of" in all the acts with respect to scope of practice. It was felt unnecessary to be in the scope of practice.

Mr J. Wilson: Okay. I think the photocopier missed this one. I just did not have it in my package so I asked the question now.

Motion agreed to.

Section 3, as amended, agreed to.

L'article 3, modifié, est adopté.

Section/article 4:

The Chair: Mr Wessenger moves that section 4 of the bill be amended by striking out "upon the prescription of an optometrist or physician" in the last two lines.

Mr Beer: We have a similar amendment which I would withdraw.

Motion agreed to.

The Chair: Mr J. Wilson moves that section 4 of the bill be amended by adding the following subsection:

"(2) In this section, 'dispense' means the final verification of an ophthalmic appliance for conformity to the prescription and the final fitting and delivery of the appliance."

1640

Mr J. Wilson: We believe that dispensing should be precisely defined in this act. There has been a great deal of debate among professionals as to what it means in this act.

We believe this definition appropriately identifies and controls the limited risk involved in the dispensing of eyewear and also preserves the role of the optician in the process.

Without a definition of "dispensing," there is no certainty as to what the government intends to be controlled and therefore to be limited to the profession of opticians and what is permitted by their unregulated assistants. Our definition of "dispensing" will ensure that no one leaves a retail eyewear outlet without having an optician examine the final product. I think that is very important. This will ensure that the proper checks are in place to protect children under the age of visual maturity and those who are purchasing contact lenses.

Our definition will also ensure that everyone who walks in with a prescription will walk out with the prescribed prescription. We believe that allowing unregulated frame stylists to assist in the choice of frames and to do initial consultation and other clerical duties associated with an ophthalmic dispenser's practice will result in cost-effective delivery of these services. I remember we argued that a great deal during the committee hearings. At the same time, enormous advances in technology are recognized and the quality of the professional service will be ensured by the timely intervention of the opticians in the final fitting and delivery stage of the ophthalmic device dispensing process.

Mr Beer: Just to try to understand more clearly the point of this amendment, would the optician not be responsible within his or her place of business for the final verification of the appliance? I am trying to understand how this would make the optician's responsibility any clearer than it is under the wording that is there. I would think that ultimately it is the responsibility of the optician that the work done by anybody in his or her employ is appropriate and would meet all the needs you have set out.

Mr J. Wilson: May I clarify, Madam Chair?

The Chair: Yes. According to the rules of procedure of committees, members can request or put questions on the record or request questions to the parliamentary assistant. If other members of the committee are not witnesses before the committee, they cannot be compelled to answer. However, Mr Wilson would like to respond.

Mr J. Wilson: Perhaps I will clarify it, because Mr Beer points out exactly the argument. We feel very strongly that the word "dispense" needs to be defined. I think Mr Beer agrees with us that the word "dispense" means the final verification. You know pretty well whether your eyeglasses enable you to see properly or not. We do not believe the optician must be involved in every single stage of the process of filling out the prescription, but we believe very strongly that consumers should not leave the eyewear shop until an optician has given final verification that the glasses meet exactly the prescription as prescribed.

Because you point out exactly the debate that is going on, we look for support to clarify the meaning of the word "dispense." The understanding you have, Mr Beer, is not shared by everyone and yet we agree with your understanding and would like to see it clarified in the act.

Mr Beer: You make it very difficult not to agree with you and everything you have said.

Mr J. Wilson: I am doing my best.

Mr Beer: Can I ask the parliamentary assistant if he could comment on the sense of "dispense", if I can put it that way, in this section as the government has drafted it and to comment on what our colleague has said?

Mr Wessinger: Perhaps I could reiterate from memory the position with respect to the opticians. It was strongly opposed by the professional associations and the board.

Mr Beer: What was strongly opposed?

Mr Wessinger: This definition that is proposed by Mr Wilson was strongly opposed at the hearings by the professional opticians because they felt it would have an impact on the role of the opticians. They felt it would result in layoffs and reduced job opportunities for them. They also were concerned about the fact that it would reduce the quality of the programs. There was some debate with respect to the opticians and another group that took the opposing position, but they were certainly concerned about the quality of programs and felt it was necessary to not lessen the definition of "dispense."

There is a minor problem with the subsection in the term "ophthalmic appliance." It is not a correct definition, I am advised. The other aspect is that the same result that is set out in the proposed amendment could be achieved through delegation by an optician.

Mr Beer: So in point of fact, in reading the way it is worded, the optician is responsible for what goes on within his or her place of business.

Mr Wessinger: There is no question that this amendment would loosen control over the dispensing exercise by the governing body of opticians. That would be the effect of the amendment.

The Chair: All those in favour of the amendment? Those opposed?

Motion negated.

Section 4, as amended, agreed to.

L'article 4, modifié, est adopté.

The Chair: Mr Wessinger moves that the bill be amended by adding the following section:

"4.1(1) A member shall not dispense subnormal vision devices, contact lenses or eyeglasses under the authority of section 4 except upon the prescription of an optometrist or physician.

"(2) In addition to the grounds set out in subsection 49(1) of the health professions procedural code, a panel of the discipline committee shall find that a member has committed an act of professional misconduct if the member contravenes subsection (1)."

Motion agreed to.

Section 5 agreed to.

L'article 5 est adopté.

Section/article 6:

The Chair: Mr Wessinger moves that clause 6(1)(a) of the bill be amended by striking out "at least eight and no

more than twelve" in the first line and substituting "at least seven and no more than ten."

And he further moves that clause 6(1)(b) of the bill be amended by striking out "at least four and no more than six" in the first line and substituting "at least five and no more than eight."

The Chair: All those in favour of the amendment? Any opposed?

Motion agreed to.

Section 6, as amended, agreed to.

L'article 6, modifié, est adopté.

Section 7 agreed to.

L'article 7 est adopté.

Section/article 8:

The Chair: Shall section 8 stand as part of the bill? All those in favour? Any opposed?

Section 8 deleted.

L'article 8 est rayé.

Sections 9 to 14, inclusive, deleted.

Les articles 9 à 14, inclusivement, sont rayés.

Section/article 15:

The Chair: Mr Wessinger moves that subsection 15(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

Motion agreed to.

Section 15, as amended, agreed to.

L'article 15, modifié, est adopté.

Sections 16 and 17 agreed to.

Les articles 16 et 17 sont adoptés.

Section/article 18:

The Chair: Shall section 18 stand as part of the bill? All those in favour? Any opposed?

Section 18 deleted.

L'article 18 est rayé.

1650

Sections 19 to 21, inclusive, agreed to.

Les articles 19 à 21, inclusivement, sont adoptés.

Section/article 22:

The Chair: Mr Wessinger moves that section 22 of the bill be amended by adding the following subsection:

"(4) Despite subsection (1), section 81.1 of the health professions procedural code, as it applies in respect of this act, does not come into force until one year after this act comes into force."

Section 22, as amended, agreed to.

L'article 22, modifié, est adopté.

Section 23 agreed to.

L'article 23 est adopté.

Title agreed to.

Le titre est adopté.

The Chair: Shall the bill, as amended, carry? All those in favour? Any opposed? Carried.

The Chair: All members have received the information regarding Bill 60, An Act respecting the regulation of

the Profession of Optometry. We have two additional amendments, one to section 3 and one to section 4. These replace the ones you have in your packet. Mr Wilson?

Mr J. Wilson: Perhaps I may request a 10-minute recess.

The Chair: We have a request for a 10-minute recess. The committee stands in recess until 5:00 pm.

The committee recessed at 1651.

1704

OPTOMETRY ACT, 1991

LOI DE 1991 SUR LES OPTOMÉTRISTES

Sections 1 and 2 agreed to.

Les articles 1 et 2 sont adoptés.

The Chair: There are several amendments for section 3. Mr Wilson's motion is first in the order in which they were received.

Mr J. Wilson: It is a little tricky here, Madam Chair. I will agree to stand down my motions on both section 3 and section 4 if the government will stand down its two amendments. We just received today the final wording of the government's amendments. I think it would give the Ontario Association of Optometrists and all members sufficient time to study the new wording if we stood it down until next week, either November 4 or 5, because it is a little complicated. I have heard some reverberations from the association of optometrists that perhaps the government's new wording today is not an improvement upon the government amendments that were in our package prior to today. I would agree to stand down mine if the government members would agree to stand down theirs.

Mr Beer: I would like to support what our colleague has just said. There have been a number of discussions around the wording here, but as recently as this morning another possible way of expressing the scope of practice has come forward. I think we should stand down all the amendments to this section so that we can provide for the optometrists to look more thoroughly at the government's proposal and also, quite frankly, give all of us a chance to talk with them, because I think with all these different proposals coming forward and different ideas as to what they mean, it might help us. I do not think it would hurt if in fact we finalized it next Monday or Tuesday. I think we can deal with the other parts of the bill. There are two sections that are related to the scope of practice, and if we could stand those down it would be useful.

Mr Owens: I have just a quick question for Mr Wilson. Are you looking at dealing with this issue next week, next Monday or—

Mr J. Wilson: That would be agreeable. Monday or Tuesday would be fine with us.

Mr Owens: We do not have a problem with standing those issues down to give the profession an opportunity to look at the wording.

The Chair: We will stand down section 3 and section 4 until either next Monday or Tuesday, as time permits. We will deal with them at the conclusion of the package of bills.

Section 5 agreed to.

L'article 5 est adopté.

Section/article 6:

The Chair: Mr Wessenger moves that clause 6(1)(a) of the bill be amended by striking out "at least six and no more than ten" in the first line and substituting "at least eight and no more than nine."

And he further moves that clause 6(1)(b) of the bill be amended by striking out "at least four and no more than six" in the first line and substituting "at least seven and no more than eight."

And he further moves that clause 6(1)(c) of the bill be struck out and the following substituted:

"(c) one person selected in the prescribed manner from among members who are members of a faculty of optometry of a university in Ontario."

The Chair: All those in favour of the amendment? Any opposed?

Motion agreed to.

Section 6, as amended, agreed to.

L'article 6, modifié, est adopté.

Section 7 agreed to.

L'article 7 est adopté.

Section/article 8:

The Chair: Shall section 8 stand as part of the bill? All those in favour? Those opposed?

Section 8 deleted.

L'article 8 est rayé.

Sections 9 to 14, inclusive, withdrawn.

Les articles 9 à 14, inclusivement, sont rayés.

Section 15 agreed to.

L'article 15 est adopté.

Section/article 16:

The Chair: Mr Wessenger moves that subsection 16(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

Motion agreed to.

Section 16, as amended, agreed to.

L'article 16, modifié, est adopté.

Sections 17 and 18 agreed to.

Les articles 17 et 18 sont adoptés.

1710

Section/article 19:

The Chair: Mr Wessenger moves that section 19 of the bill be amended by striking out "college" in the third line and substituting "council" and by striking out clause (c).

Motion agreed to.

The Chair: Mr Wessenger moves that clause 19(b) of the bill be amended by striking out "number" in the first line.

Motion agreed to.

Section 19, as amended, agreed to.

L'article 19, modifié, est adopté.

Sections 20 to 22, inclusive, agreed to.

Les articles 20 à 22, inclusivement, sont adoptés.

Section/article 23:

The Chair: Mr Wessenger moves that section 23 of the bill be amended by adding the following subsection:

"(4) Despite subsection (1), section 81.1 of the health professions procedural code, as it applies in respect of this act, does not come into force until one year after this act comes into force."

Motion agreed to.

Section 23, as amended, agreed to.

L'article 23, modifié, est adopté.

Section 24 agreed to.

L'article 24 est adopté.

Title agreed to.

Le titre est adopté.

The Chair: We will hold the rest down until we complete the bill.

MEDICINE ACT, 1991

LOI DE 1991 SUR LES MÉDECINS

The Chair: There was an amendment by Mr McClelland. Does everyone have the amendment? Are you ready to proceed, Mr Beer?

Mr Beer: Yes, if that is agreeable to everyone. I do not want to go into everything that was said yesterday by Mr McClelland but simply to note that this amendment speaks to concerns that were raised by psychiatric patients about the need to be clearer with respect to their rights and how these acts would operate in terms of the profession of medicine. In our view, this sets out additional grounds for misconduct that would better protect psychiatric patients.

Mr J. Wilson: I will be opposing this amendment mainly because I do not think it is appropriate at this time in the bill to bring forward an amendment, although it is very well intentioned. I had asked, prior to our last adjournment, why this amendment could not be discussed in the context of Bill 109 and the Advocacy Act where it is more appropriate and would cover all the professions.

Mr Wessinger: I would like to speak with respect to the proposed amendment. Certainly the principle of the proposed amendment is good, but unfortunately, for various reasons, I do not feel it is appropriate to support it at this time.

First, I think any amendment should be an amendment not just to this bill, the Medicine Act, but should apply to all professions. Therefore, it should be in Bill 43. I think that is the appropriate place for it. That is the first aspect of my concern.

The second aspect is that shortly we are going to be having hearings with respect to the Consent to Treatment

Act and I know the various health professions want to make certain representations with respect to that act and want to be consulted on the whole aspect of the question of consent to treatment. I think we should listen to the professions and see what representations they make with respect to the matter.

Third, I think it is appropriate that we should ask each profession to come forward with its proposal with respect to how to deal with the problem of consent, because I think there may be variations with respect to what is appropriate for each profession. I think it is very important that we get all the input and that the professions themselves be given the opportunity to deal with this matter.

I should add that it can also be dealt with under the regulations of each act, so the matter can be dealt with in a regulatory manner. Hopefully the professions will come forward with an agreed upon language that we can appropriately incorporate into their respective regulations.

Mr Beer: With respect to Bills 108 and 109, which deal with substitute decisions and consent to treatment, they do not contain any enforcement or penalty provisions. This has been of real concern to psychiatric patients in terms of how they can proceed. They feel it is very difficult, if not impossible, to persuade a justice of the peace to lay a charge if you are dealing with the Mental Health Act and that what is important is to put it into this act, which is direct and specific, and it was for that reason we have put it in here.

I think that at this point, in terms of what is going to happen to Bills 108 or 109, they would tend to be general in application. To protect the concerns raised by the psychiatric patient advocate office, the best way of dealing with that is to deal with Bill 55. For that reason, we would continue to urge that this new motion, section 17.1, additional grounds for misconduct, be approved and placed within the bill.

The Chair: All those in favour of the motion? Those opposed?

Motion negated.

The Chair: Shall the bill, as amended, carry? All those in favour? All those opposed? Carried.

That concludes the agenda for today. We will be dealing with the four outstanding bills tomorrow and then conclude on Monday, November 4, and Tuesday, November 5, as necessary, hopefully, all matters dealing with this package of legislation.

The committee adjourned at 1719.

CONTENTS

Monday 28 October 1991

Regulated Health Professions Act, 1991, and companion legislation / Loi de 1991 sur les professions de la santé réglementées et les projets de loi qui l'accompagnent	S-895
Nursing Act, 1991 / Loi de 1991 sur les infirmières et infirmiers	S-895
Occupational Therapy Act, 1991 / Loi de 1991 sur les ergothérapeutes	S-901
Opticianry Act, 1991 / Loi de 1991 sur les opticiens	S-903
Optometry Act, 1991 / Loi de 1991 sur les optométristes	S-905
Medicine Act, 1991 / Loi de 1991 sur les médecins	S-906

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Tuesday 29 October 1991

Journal des débats (Hansard)

Le mardi 29 octobre 1991

Standing committee on social development

Regulated Health
Professions Act, 1991
and companion legislation

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent



Chair: Elinor Caplan
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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 29 October 1991

The committee met at 1553 in room 151.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Suite de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

PHARMACY ACT, 1991

LOI DE 1991 SUR LES PHARMACIENS

The Chair: I will begin calling the clauses.

Sections 1 to 6, inclusive, agreed to.

Les articles 1 à 6, inclusivement, sont adoptés.

Section/article 7:

The Chair: Mr Wessenger moves that clause 7(1)(a) of the bill be amended by striking out "at least nine and no more than twenty" in the first line and substituting "at least nine and no more than seventeen."

And he further moves that clause 7(1)(b) of the bill be amended by striking out "nine" in the first line and substituting "at least nine and no more than sixteen."

All those in favour? All those opposed?

Motion agreed to.

Section 7, as amended, agreed to.

L'article 7, modifié, est adopté.

Section 8 agreed to.

L'article 8 est adopté.

Section article 9:

The Chair: Shall section 9 stand as part of the bill? All those in favour? Any opposed?

Section 9 deleted.

L'article 9 est rayé.

Sections 10 to 14, inclusive, deleted.

Les articles 10 à 14, inclusivement, sont rayés.

Section/article 15:

The Chair: Mr Wessenger moves that subsection 15(1) of the bill be struck out and the following substituted:

"(1) The college shall have an accreditation committee.

"(1.1) The council shall appoint the members of the accreditation committee.

"(1.2) The composition of the accreditation committee shall be in accordance with the regulations."

Motion agreed to.

Section 15, as amended, agreed to.

L'article 15, modifié, est adopté.

Section/article 16:

The Chair: Shall section 16 stand as part of the bill? All those in favour? Any opposed?

Section 16 deleted.

L'article 16 est rayé.

Section/article 17:

The Chair: Mr Wessenger moves that subsection 17(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

Motion agreed to.

Section 17, as amended, agreed to.

L'article 17, modifié, est adopté.

Sections 18 and 19 agreed to.

Les articles 18 et 19 sont adoptés.

Section/article 20:

The Chair: Mr Wessenger moves that section 20 of the bill be struck out and the following substituted:

"20. Subject to the approval of the Lieutenant Governor in Council and with prior review by the minister, the college may make regulations providing for the composition of the accreditation committee."

Motion agreed to.

Section 20, as amended, agreed to.

L'article 20, modifié, est adopté.

Sections 21 to 23, inclusive, agreed to.

Les articles 21 à 23, inclusivement, sont adoptés.

Section/article 24:

The Chair: Mr Wessenger moves that section 24 of the bill be amended by adding the following subsection:

"(4) Despite subsection (1), section 81.1 of the health professions procedural code, as it applies in respect of this act, does not come into force until one year after this act comes into force."

Motion agreed to.

Section 24, as amended, agreed to.

L'article 24, modifié, est adopté.

Section 25 agreed to.

L'article 25 est adopté.

Title agreed to.

Le titre est adopté.

The Chair: Shall the bill, as amended, carry? All those in favour? Any opposed? Carried.

That completes Bill 61. It will be ordered along with all of the others. Are we ready for Bill 62, An Act respecting the regulation of the Profession of Physiotherapy?

Mr Wessenger: I wonder if we could have a short recess.

The Chair: Fine. A five-minute recess has been requested by the government. The committee stands in recess for five minutes.

The committee recessed at 1559.

1604

PHYSIOTHERAPY ACT, 1991

LOI DE 1991 SUR LES PHYSIOTHÉRAPEUTES

The Chair: The standing committee on social development is now in session on Bill 62, an Act respecting the regulation of the Profession of Physiotherapy.

Sections 1 to 3, inclusive, agreed to.

Les articles 1 à 3, inclusivement, sont adoptés.

Section/article 4:

The Chair: Mr Wessenger moves that section 4 of the bill be struck out and the following substituted:

"4. In the course of engaging in the practice of physiotherapy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

"1. Moving the joints of the spine beyond a person's usual physiological range of motion using a fast, low amplitude thrust.

"2. Tracheal suctioning."

All those in favour? Any opposed?

Motion agreed to.

The Chair: Mr J. Wilson moves that section 4 of the bill be struck out and the following substituted:

"4. In the course of engaging in the practice of physiotherapy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

"1. Communicating a diagnosis within the scope of practice of physiotherapy."

"2. Moving the joints of the spine beyond a person's usual physiological range of motion using a fast, low amplitude thrust.

"3. Tracheal suctioning."

Mr J. Wilson: The intent of the amendment, which differs from the government amendment we just passed, is that we believe physiotherapists should be allowed to communicate a diagnosis within their scope of practice. At present, physical therapists routinely communicate to their clients their findings of physical disorders or dysfunctions. This communication is not only necessary for the patient to understand his condition and the treatment plan suggested by the therapist but is most important for the patient to give informed consent to further treatment of his condition. It will also severely limit the usual practice of advising and educating the patient on methods of treatment and prevention if physical therapists are not permitted to communicate a diagnosis within their scope of practice.

Mr Wessenger: I will be opposing this amendment, as I have opposed the other amendments, because we believe physical therapists do not diagnose but do assessments only.

The Chair: All those in favour? Any opposed?

Motion negated.

Section 4, as amended, agreed to.

L'article 4, modifié, est adopté.

Section 5 agreed to.

L'article 5 est adopté.

Section/article 6:

The Chair: Mr Wessenger moves that clause 6(1)(a) of the bill be amended by striking out "at least seven and no more than ten" in the first line and substituting "at least seven and no more than eight."

And he further moves that clause 6(1)(b) of the bill be amended by striking out "at least four and no more than six" in the first line and substituting "at least five and no more than seven."

The Chair: All those in favour? Any opposed?

Motion agreed to.

Section 6, as amended, agreed to.

L'article 6, modifié, est adopté.

Section 7 agreed to.

L'article 7 est adopté.

Section/article 8:

The Chair: Shall section 8 stand as part of the bill? All those in favour? Any opposed?

Section 8 deleted.

L'article 8 est rayé.

Sections 9 to 14, inclusive, deleted.

Les articles 8 à 14, inclusivement, sont rayés.

Section/article 15:

The Chair: Mr Wessenger moves that subsection 15(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

Motion agreed to.

1610

The Chair: Mr McClelland moves that subsection 15(1) of the bill be amended by adding after "physiotherapist" in the second line "physical therapist."

Mr McClelland: The interchangeability is customary within the professional practice. It is in simple language to make it more consumer friendly, and appropriately so, for those individuals in society who are using the services of physiotherapists and physical therapists and who often see them as one and the same. Indeed, it is recognized as such within the profession.

Mr J. Wilson: Members will note that our amendment following is exactly the same. Therefore, we would like to support the Liberal amendment put forward by Mr McClelland. To add to what he said, I remind members that both titles are currently protected under the Drugless Practitioners Act and are protected in analogous legislation in seven of nine other provinces that have similar legislation.

Mr Wessenger: We will be supporting this amendment.

Motion agreed to.

The Chair: Mr Wilson, you are withdrawing your amendment?

Mr J. Wilson: Yes, Madam Chair.

Section 15, as amended, agreed to.

L'article 15, modifié, est adopté.

Sections 16 and 17 agreed to.

Les articles 16 et 17 sont adoptés.

Section/article 18:

The Chair: Mr Wessenger moves that section 18 of the bill be amended by striking out "college" in the third line and substituting "council" and by striking out clause (b).

Motion agreed to.

Section 18, as amended, agreed to.

L'article 18, modifié, est adopté.

Sections 19 to 21, inclusive, agreed to.

Les articles 19 à 21, inclusivement, sont adoptés.

Section/article 22:

The Chair: Mr Wessenger moves that section 22 of the bill be amended by adding the following subsection:

"(4) Despite subsection (1), section 81.1 of the health professions procedural code, as it applies in respect of this act, does not come into force until one year after this act comes into force."

Motion agreed to.

Section 22, as amended, agreed to.

L'article 22, modifié, est adopté.

Section 23 agreed to.

L'article 23 est adopté.

Title agreed to.

Le titre est adopté.

The Chair: Shall the bill, as amended, carry? All those in favour? Any opposed? Carried.

PSYCHOLOGY ACT, 1991

LOI DE 1991 SUR LES PSYCHOLOGUES

The Chair: Are we ready to proceed with Bill 63?

Sections 1 to 3, inclusive, agreed to.

Les articles 1 à 3, inclusivement, sont adoptés.

Section/article 4:

The Chair: Mr Wessenger moves that section 4 of the bill be struck out and the following substituted:

"4. In the course of engaging in the practice of psychology, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to communicate a diagnosis identifying, as the cause of a person's symptoms, a neuropsychological disorder or a psychologically based psychotic, neurotic or personality disorder."

Mr Wessenger: This just takes out the word "dysfunction" from the previous description of the authorized act.

Motion agreed to.

Section 4, as amended, agreed to.

L'article 4, modifié, est adopté.

Section 5 agreed to.

L'article 5 est adopté.

Section/article 6:

The Chair: Mr Wessenger moves that clause 6(1)(a) of the bill be amended by striking out "at least six and no

more than nine" in the first line and substituting "at least five and no more than seven".

And he further moves that clause 6(1)(b) of the bill be amended by striking out "at least four and no more than six" in the first line and substituting "at least five and no more than eight."

All those in favour? Any opposed?

Motion agreed to.

Section 6, as amended, agreed to.

L'article 6, modifié, est adopté.

Section 7 agreed to.

L'article 7 est adopté.

Section/article 8:

The Chair: Shall section 8 stand as part of the bill? All those in favour? Any opposed?

Section 8 deleted.

L'article 8 est rayé.

Sections 9 to 14, inclusive, deleted.

Les articles 9 à 14, inclusivement, sont rayés.

Section/article 15:

Mr Wessenger: I am going to ask that section 15 stand down until Monday because there are discussions between the PhDs and the MAs in psychology which may indicate the need for amendments.

The Chair: Is it agreed that all of section 15 be stood down until next Monday?

Agreed to.

Sections 16 and 17 agreed to.

Les articles 16 et 17 sont adoptés.

The Chair: Mr McClelland, you were going to withdraw section 15.1.

Mr McClelland: I think that would be appropriate, but inasmuch as the whole matter is—

The Chair: Section 15 is a separate section. Section 15.1 was a new section. It is my understanding that you wanted to withdraw it.

Mr McClelland: We will withdraw it.

Section/article 18:

The Chair: Mr Wessenger moves that section 18 of the bill be amended by striking out "college" in the third line and substituting "council" and by striking out clause (b).

Motion agreed to.

Section 18, as amended, agreed to.

L'article 18, modifié, est adopté.

Sections 19 to 21, inclusive, agreed to.

Les articles 19 à 21, inclusivement, sont adoptés.

Section/article 22:

The Chair: Mr Wessenger moves that section 22 of the bill be amended by adding the following subsection:

"(4) Despite subsection (1), section 81.1 of the health professions procedural code, as it applies in respect of this act, does not come into force until one year after this act comes into force."

Motion agreed to.

Section 22, as amended, agreed to.

L'article 22, modifié, est adopté.

Section 23 agreed to.

L'article 23 est adopté.

Title agreed to.

Le titre est adopté.

The Chair: We cannot call the bill as we have one section outstanding. That will be dealt with, for those who are interested, on Monday.

1620

RESPIRATORY THERAPY ACT, 1991

LOI DE 1991 SUR LES INHALOTHÉRAPEUTES

The Chair: Are we ready to proceed with Bill 64?

Sections 1 and 2 agreed to.

Les articles 1 et 2 sont adoptés.

Section/article 3:

The Chair: Mr Wessenger moves that section 3 of the bill be amended by striking out "on the order of a member of the College of Physicians and Surgeons of Ontario" in the fifth, sixth and seventh lines.

Motion agreed to.

Section 3, as amended, agreed to.

L'article 3, modifié, est adopté.

Section/article 4:

The Chair: Mr Wessenger moves that paragraphs 1 and 2 of section 4 of the bill be struck out and the following substituted:

"1. Performing a prescribed procedure below the dermis.

"2. Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx.

"3. Suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx.

"4. Administering a substance by injection or inhalation."

Mr Wessenger: It has been reworded.

Mr J. Wilson: I have a question for the parliamentary assistant. Was any consideration given concerning the controlled act of allergy testing? That came up in our discussions with the respiratory therapists.

Mr Wessenger: I will ask counsel to reply to that one.

Ms Bohnen: The ministry has also had discussions with the profession about that. Their concern had to do with whether they would be permitted to administer by injection or inhalation substances used to perform allergy tests. We have assured them that the ordering of the administration of substances by the physician will certainly include antigens, the substances used for allergy testing. I do not believe they need to have a concern about this.

Motion agreed to.

Section 4, as amended, agreed to.

L'article 4, modifié, est adopté.

The Chair: Mr Wessenger moves that the bill be amended by adding the following section:

"4.1(1) A member shall not perform a procedure under the authority of paragraph 1, 2 or 4 of section 4 unless the procedure is ordered by a member of the College of Physicians and Surgeons of Ontario.

"(2) In addition to the grounds set out in subsection 49(1) of the health professions procedural code, a panel of the discipline committee shall find that a member has committed an act of professional misconduct if the member contravenes subsection (1)."

Motion agreed to.

Section 5 agreed to.

L'article 5 est adopté.

Section/article 6:

The Chair: Mr Wessenger moves that clause 6(1)(a) of the bill be amended by striking out "at least eight and no more than twelve" in the first line and substituting "at least seven and no more than ten."

And he further moves that clause 6(1)(b) of the bill be amended by striking out "at least four and no more than six" in the first line and substituting "at least five and no more than eight."

All those in favour? Any opposed?

Motion agreed to.

Section 6, as amended, agreed to.

L'article 6, modifié, est adopté.

Section 7 agreed to.

L'article 7 est adopté.

Section/article 8:

The Chair: Shall section 8 stand as part of the bill? All those in favour? Any opposed?

Section 8 deleted.

L'article 8 est rayé.

Sections 9 to 14, inclusive, deleted.

Les articles 9 à 14, inclusivement, sont rayés.

Section/article 15:

The Chair: Mr Wessenger moves that subsection 15(1) of the bill be amended by striking out "in the course of providing or offering to provide, in Ontario, health care to individuals" in the last three lines.

Motion agreed to.

Section 15, as amended, agreed to.

L'article 15, modifié, est adopté.

Sections 16 and 17 agreed to.

Les articles 16 et 17 sont adoptés.

Section/article 18:

The Chair: Shall section 18 stand as part of the bill? All those in favour? Any opposed?

Section 18 deleted.

L'article 18 est rayé.

Sections 19 and 20 agreed to.

Les articles 19 et 20 sont adoptés.

Section/article 21:

The Chair: Mr Wessenger moves that section 21 of the bill be amended by adding the following subsection:

"(4) Despite subsection (1), section 81.1 of the health professions procedural code, as it applies in respect of this act, does not come into force until one year after this act comes into force."

Mr J. Wilson: Just as a last hurrah, I put on the record that I will be opposing this amendment because it deals

with the patient relations committee and program, which we believe ignore the right of compensation for victims of sexual abuse.

Mr Owens: Just to comment on Mr Wilson's comment, we do not feel that compensation is the sole criterion for dealing with the victims of sexual abuse. I will be quite pleased to support this amendment.

Mr J. Wilson: We do not believe it is the sole criterion either, but it certainly is an important part of any program that would come forward. We believe the patient relations program is incomplete and that is why we are unable to support this amendment in each of the bills.

The Chair: All those in favour? Any opposed?
Motion agreed to.

Section 21, as amended, agreed to.
L'article 21, modifié, est adopté.

Section 22 agreed to.
L'article 22 est adopté.

Title agreed to.
Le titre est adopté.

The Chair: Shall the bill, as amended, carry? All those in favour? Any opposed? Carried.

This will be ordered with the others. Further business for today? The committee stands adjourned until next Monday at 3:30.

The committee adjourned at 1629.

CONTENTS

Tuesday 29 October 1991

Regulated Health Professions Act, 1991, and companion legislation / Loi de 1991 sur les professions de la santé réglementées et les projets de loi qui l'accompagnent	S-907
Pharmacy Act, 1991 / Loi de 1991 sur les pharmaciens	S-907
Physiotherapy Act, 1991 / Loi de 1991 sur les physiothérapeutes	S-908
Psychology Act, 1991 / Loi de 1991 sur les psychologues	S-909
Respiratory Therapy Act, 1991 / Loi de 1991 sur les inhalothérapeutes	S-910

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

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Monday 4 November 1991

Standing committee on social development

Regulated Health
Professions Act, 1991
and companion legislation

Assemblée législative de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le lundi 4 novembre 1991

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent



Chair: Elinor Caplan
Clerk: Lynn Mellor

Présidente : Elinor Caplan
Greffière : Lynn Mellor

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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 4 November 1991

The committee met at 1534 in room 151.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Suite de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

The Chair: The standing committee on social development is now in session. It is my understanding that the Minister of Health will be here in approximately 15 minutes so I am going to suggest a slight reordering of the agenda and ask if the legislative counsels who are here and ready to proceed will begin with the discussions around translation of our French-language portions of the bill.

Mr Spakowski: Good afternoon. I would like to introduce my colleagues from the office of the legislative counsel. Donald Revell is chief legislative counsel and Michel Moisan is the head of our translation and linguistic services.

Last week a question was asked about the masculine and feminine forms in the French titles of some of the bills before the committee. This question raises a difficult issue. It involves two principles that are very important to our office, that our drafting be gender-neutral, and that our drafting be clearly written in proper French and English. These are principles that are not always easy to reconcile. Furthermore, their reconciliation is different in the two different languages. We have considered this matter and we are of the opinion that the way it has been dealt with reflects current French usage. We would be happy to answer any questions the committee might have.

Mr Beer: Thank you very much for the letter and the accompanying documents. I do not want to hold us up too long on this question. I think you have addressed the issues. I was just wondering, in terms of this overall question, is there a protocol, if you like, in terms of the way Parliament in Ottawa, the National Assembly in Quebec and the New Brunswick Legislative Assembly deal with these questions of terminology? I just wonder if there is something similar. I was not sure whether that might have been noted in the document. I did not see it and I wondered whether there was an attempt to use common terminology in both languages.

Mr Moisan: As far as I know, other bilingual jurisdictions try to follow current French usage. The general way of translating position titles, for example, in French would be to use the generic masculine. As you know, there is an exception in the case of the nurses. That is an exception

you can also find in Quebec statutes and New Brunswick statutes, so other jurisdictions follow the same rules.

Mr Beer : En terminant, je dirais simplement que je pense que c'est une des questions qui deviennent importantes à cause du fait que, de plus en plus, on essaie de mettre le terme correct à ces titres. Si on peut suivre la même approche qu'on suit à Ottawa, à Québec ou à Fredericton, où on a d'autres Assemblées législatives qui utilisent la langue française, je pense que ça peut être utile. Mais, je vous remercie pour la réponse à ma question de la semaine passée. Merci beaucoup.

Ms Haeck: I appreciate Mr Beer's remarks as well as your own. I was just wondering if in some respects we are not sending a message that—how shall I put it? I am trying to be diplomatic here. Generally we are going to set an example of inclusion as opposed to exclusion. I understand that the basic form, and for many years the basic title for a lot of things was "he." That was the standard term when referring to contract language or whatever. In these days there are definitely many exceptions. I was wondering if we could not begin by setting an example that in fact both sexes are included in the title.

Mr Moisan: You have to remember that you are dealing with two very different languages here. French does not work the same way as English. You are absolutely right with "he" in English. Of course we have changed that in the recently revised statutes. In French, it is another matter altogether. The masculine generic is still considered inclusive in French in properly written text. That is why we use it and that is why other bilingual jurisdictions in the country use it. Obviously there are changes in the language in French as well as in English. We monitor the situation, and if the French language ever changes enough that we feel we are no longer following current usage by using the masculine generic, obviously we will revise our way of doing things.

Ms Haeck: The Académie française has not yet been picketed by women's groups as far as changing usage is concerned. Is that what you are telling me?

Mr Moisan: The Académie française, of course, is a very important sort of regulating body but it is not the only source of current usage. We look at the French press—when I say "French" I mean Quebec and New Brunswick, as well as France and Belgium—and we try to see what the present state of the language is, whatever the Académie says.

Ms Haeck: I see. I appreciate it. I hope you will excuse my facetiousness, but I had wondered how inclusive we could be in the North American context.

Mr Grandmaitre: My question is a very sincere one. Since the implementation of Bill 8, how have you been reacting or trying to accommodate the needs of Bill 8? What have you done in the present ministry or whatever?

Mr Revell: Unquestionably the most significant thing we have done, Mr Grandmaitre, is to do the Revised Statutes of Ontario. I am not sure whether all the members have received the Revised Statutes of Ontario 1990 in their offices yet, but it is a 12-volume set. It contains the 547 public and general statutes of the province in fully bilingual form. That is our most significant step. Those statutes will be proclaimed in force on 31 December of this year, which is in full compliance with Bill 8.

The next thing we are doing is we have an ongoing project in the office to translate the existing body of regulations into French. We estimate this project to be about a five-year project in total. There was no mandate in the French Language Services Act for us to do this. There was a mandate on the Attorney General to select appropriate regulations. In fact, we have gone beyond just selecting appropriate regulations. We are attempting to have the great bulk of Ontario regulations in French by 1995. Of course, all new bills have been drafted in bilingual form since the beginning of the year.

Mr Grandmaitre: But did you not have a deadline, though, of 1991? Did you not have five years to do all the needed translation? Was this not the program?

Mr Revell: On the regulations there is no deadline. On the statutes the deadline is indeed 1991 and that deadline is being fully complied with. It is December 31, 1991.

The Chair: Further speakers? On behalf of the committee I would like to thank you both very much for the clarification, the presentation today and the very fine work you have done in preparing the legislation. I know it is not often that we have an opportunity to see the people who prepare everything for us behind the scenes, and I think it would be appropriate. I know on behalf of all committee members we are very impressed with the work you have done and the thought you put into it. We would like to thank you very much.

My suggestion is that we recess until the minister shows up. How about starting with a five-minute recess, and hopefully the minister will be here at that time?

Clerk of the Committee: She is just outside the door.

The Chair: She is just outside the door? Okay, five minutes should do it.

The committee recessed at 1543.

1549

The Chair: The standing committee on social development is in session. Are we ready to proceed? We are doing clause-by-clause discussion. We will begin with Bill 43. I would like to welcome the Minister of Health to our deliberations this afternoon.

Hon Ms Lankin: Thank you very much. I would like to officially table the proposed amendments with respect to Bills 43 and 56. They will be read into the record officially a little later when Mr Wessinger moves them, but I wanted to take a moment to address these amendments. I believe the committee members have them in front of them. You have had a chance to look at them. As you know, the purpose of these amendments is to acknowledge through exemption the practice of traditional healing and midwifery by members of aboriginal communities in Ontario.

These amendments the government is proposing today have evolved from discussions with aboriginal groups that took place since early this summer. I think it is fair to say that the first bill which raised these issues for us was the Midwifery Act. In the context of reviewing that, it served as a catalyst for aboriginal groups to express their concerns about the potential negative impact that the regulation of, first of all, midwifery, and then the discussion was broadened, would have on health services, particularly on the traditional midwives and possibly traditional healers in aboriginal communities.

Those organizations certainly expressed to us a very clear desire to have access to health care providers who are representatives of their culture and communities. As well, of course, they would like to have access to technology that is offered by allopathic care institutions. I think there is a clear indication that there are two streams of health care that are recognized through the aboriginal communities.

In the summer there was a brief consultation conducted by aboriginal groups and they proposed that aboriginal healers and midwives should be exempted from the legislation. The proposed amendments provide an exemption, but I think it is important that in the way we have tried to structure it, the exemption is for aboriginal healers and midwives when they provide services to aboriginal persons and to members of aboriginal communities. We have defined "aboriginal healer" as an aboriginal person who is providing traditional healing services and we have defined an "aboriginal midwife" as an aboriginal person who is providing traditional midwifery services.

I think one of the things that is important about the proposed wording is it recognizes that there are aboriginal communities other than Indian reserves as set out in the Indian Act. That was important because when we first started looking at it and speaking with some of the aboriginal community groups about how an exemption might be framed and how it might be applied, we looked at the issue of jurisdiction and the issue of band councils or others and we found very quickly that there were communities that would then fall outside the exemption, that it would not address the actual structure of where these traditional services are currently being performed; for example, Metis settlements in defined geographic areas or first nations without a land base at this point in time or a defined aboriginal population within an urban area. We certainly had clear examples and representations from groups of that nature.

The proposed amendments also recognize that an aboriginal healer or midwife may become a member of a college. Should they choose this approach, they would then be subject to the college regulations. We hoped that would address concerns on that side of it.

The proposed amendment to Bill 56 would permit an aboriginal person practising midwifery to call herself an aboriginal midwife.

All in all, we believe these amendments are an appropriate response to the aboriginal aspirations for the recognition of the current practice and the potential revitalization of traditional healing. I was impressed in my discussions with representatives of the community with how important that was to them as a whole. As indicated by the aboriginal communities,

these traditional midwifery and healing practices have been in existence for thousands of years and they have been under the governance of aboriginal communities and elders throughout this time. Those governance structures are different than what we propose in terms of how we regulate our processes and our services within our cultural definition of these things. This approach recognizes that difference.

These and other aboriginal health issues will be discussed on an ongoing basis as we develop an aboriginal health policy. We expect that process will span the next several months. I think in our preliminary discussions with representatives of aboriginal communities, we have had a suggested timetable to begin these broader consultations. We know that some of the things we may be discussing would be assisting those communities in establishing their own regulatory structure. There have been discussions about the possibility of an aboriginal native midwifery council. There are a number of things we are looking at exploring in joint consultation.

We think the broader framework of aboriginal health issues is very important for our province and important for us to continue discussions on. This is not a process that ends with these proposals we are putting forward. We want to develop jointly, and that was expressed by both sides to the consultation, the appropriate policy and structures that will guide the development and the delivery of services to the aboriginal community. We felt it was important to start that from the premise of what in practice and in history has been the case, that our aboriginal communities have had access to traditional healers and midwives in a delivery of service based in culture and history. That varies very much from those services under the proposed legislation and proposed bills that we are now determining to regulate in a different way.

I will leave my comments at that and perhaps can provide some other thoughts after hearing what other members of the committee have to say.

The Chair: I think it might be appropriate if we asked for the motions to be formally read into the record and then we can have discussion.

Mr Wessinger moves that the bill be amended by adding, after the heading "Miscellaneous", the following section:

"31.1(1) This act does not apply to,

"(a) aboriginal healers providing traditional healing services to aboriginal persons or members of an aboriginal community; or

"(b) aboriginal midwives providing traditional midwifery services to aboriginal persons or members of an aboriginal community.

"(2) Despite subsection (1), an aboriginal healer or aboriginal midwife who is a member of a college is subject to the jurisdiction of the college.

"(3) In this section,

"'aboriginal healer' means an aboriginal person who provides traditional healing services;

"'aboriginal midwife' means an aboriginal person who provides traditional midwifery services."

Mr Beer: I want to indicate at the outset that we will be supporting this amendment. I think the premise on

which you based it is one that we have been trying to move towards for a number of years now in the provision of social services where previous governments have reached agreements with aboriginal bands around the provision of those services, as well as in other areas of health care.

The only point I would like to make in relation to this is simply the one you referred to. I encourage you to go forward in terms of the governance structures as we try to work with those structures that have historically existed, but there is none the less a concern we have had throughout, in dealing with all of this legislation, around the public interest, that there be developed a clear understanding of how this is in fact governed. I am sure for all of us, whether we are talking about aboriginal or non-aboriginal persons who may be receiving health care service from an aboriginal healer or an aboriginal midwife, there is a need, just as there is with the broader legislation, to have a clear understanding of the governance structures so that what we want to see happen here does happen.

1600

You made reference to one of the issues you were exploring with the native leadership, perhaps around the creation of an aboriginal native midwifery council, which sounds like an interesting proposal. With whom are you developing these structures? Is this with the different bands or with two or three of the specific province-wide aboriginal organizations?

Hon Ms Lankin: It has been a combination. I do not actually have the list with me, but the people with whom we have met to date include groups such as the Union of Ontario Indians, Equay Wuk from NAN—let me get the names right—is it the Association of Iroquois and Six Nations? I think those may be some of the names. I am not very good at getting them all out yet, but there are a variety of those groups. There are some province-wide groups and particular treaty groups that have not been involved yet. Here we go: There is the Association of Iroquois and Allied Indians. We have not yet been able to have Grand Council Treaty 3 involved in the process because the kind of time frames we imposed on the groups were very difficult for all the groups to meet. Some of them were able to do some limited consultation with their own communities. We hope Grand Council Treaty 3 will be involved from here on in.

There is the Nishnawbe-Aski Nation, and I mentioned Equay Wuk specifically. There are the Ontario Federation of Indian Friendship Centres, the Ontario Métis and Aboriginal Association, the Ontario Native Women's Association, and the union, as I mentioned. The Chiefs of Ontario were not able to attend the last meeting we had, but we will, I am sure, have them involved from here on in.

We will take a moment with those groups to ensure that we have the appropriate list of people and that we are not missing specific organizations, but also to ensure that in the process we put in place now for a consultation, clearly we do not have the kind of unrealistic time frames placed on the groups that we had in leading up to these exemptions, and that we allow for sufficient time and resources for them to do proper consultations, which they

feel are proper, with their own communities to bring forward the best consensus of ideas.

Mr J. Wilson: I want to very briefly commend the minister for bringing forward the amendments and for appearing before the committee in person today. I think that underlines the importance of the issue for committee members. It also ensures that the NDP members are quieter today than they normally are.

Interjections.

The Chair: Order. I knew that was going to provoke a response, Mr Wilson. I have cautioned others in the past not to provoke.

Mr J. Wilson: It was getting a little dull.

In all seriousness, thank you, Minister. I had an opportunity, of course, over the weekend to review the amendment and I do not have any major concerns at all. I have implicit faith that you are negotiating and ensuring that the information about governance will get out to the communities affected. I can understand that the time frames were tight. I am very appreciative, as a committee member, that you have been able to come back before the windup of our debate on Bill 43 to bring forward this amendment. Good work.

Mr Beer: One thing I forgot to say is that we will be withdrawing our amendments, and as I said before, we will be supporting the government amendments.

Mr Martin: I also want to express how important this is from my perspective in terms of a sign to the native community and in terms of recognition of what they have done for years, and the respect in which, because of this, they are now being held and will be held, and in which they will be held in the communities I am closest to in northern Ontario. I think in the context of everything else that is happening in this country today as Canada evolves, this piece is probably even larger than we, at this moment here in this room, can really appreciate and understand. In supporting this particular amendment to the bill, I am rather proud today.

Motion agreed to.

Schedule/annexe 2:

The Chair: We have had a withdrawal of Mr Beer's two motions. We have an outstanding section that has not been called. Perhaps it was just overlooked. It was Section 91 of Schedule 2.

Section 91 agreed to.

L'article 91 est adopté.

Title agreed to.

Le titre est adopté.

The Chair: Shall the bill, as amended, carry? All those in favour? Any opposed? Carried. It will be ordered with the rest of the bills when we have concluded them all.

MIDWIFERY ACT, 1991

LOI DE 1991 SUR LES SAGES-FEMMES

The Chair: I would ask for unanimous consent from the committee to reopen section 15 so that the government can place its amendment.

Agreed to.

Section/article 15:

The Chair: Mr Wessenger moves that section 15 of the bill be amended by adding the following subsection:

"(2.1) an aboriginal person who provides traditional midwifery services may,

"(a) use the title "aboriginal midwife," a variation or abbreviation or an equivalent in another language; and

"(b) hold himself or herself out as a person who is qualified to practise in Ontario as an aboriginal midwife."

Motion agreed to.

Section 15, as amended, agreed to.

L'article 15, modifié, est adopté.

The Chair: Shall Bill 56, as amended, carry? All those in favour? Any opposed? Carried.

We have now completed both Bills 43 and 56. I believe you want to stand down Bill 60.

Hon Ms Lankin: Yes.

The Chair: We have had a request from the government to deal with Bill 60 tomorrow, if that is agreed. For anyone with an interest in Bill 60, tomorrow at 3:30 in the afternoon the committee will be considering Bill 60.

I believe you are prepared to proceed with Bill 63.

Hon Ms Lankin: We are. Actually, I will be leaving at this time and handing it back over to Mr Wessenger.

Perhaps if I could say a few words to the committee with respect to the two bills that the amendments were just passed on, I sincerely appreciate the support from all members on this committee. I think, Mr Martin, you are right in terms of indicating the historic importance of these amendments and the part they play in the process of developing a relationship on a government-to-government basis and developing an understanding of things like the inherent right to self-government. This is a process we are all engaged in in this province that has importance on a national level. I think all of us feel a sense of accomplishment at each step along the way as we try to work through this. The consultations that will follow this will be very important and will have more of a basis of opportunity for success because of the committee's support for this kind of starting point, and I truly appreciate that.

Just before I leave, let me say, as you will be closing the clause-by-clause very quickly, my great sense of appreciation of the overall work the committee has done on this package of bills. As we have all said, it has had a very long history. There are all sorts of groups whose careers and professions are affected by the work you have been doing that have come to me and have been very pleased with the process of understanding and amendments and compromise where that has been able to be achieved. A number of people are very impressed and appreciative of the process the committee has undertaken, and I certainly appreciate that work as well.

The Chair: I point out to all members of the committee that you received today a copy of an agreement that has been reached. I know the committee received many representations and deputations on the issues contained in the agreement and the amendments that are being tabled by the government today are a reflection of the agreement. I know there are people here with a great interest in that.

1610

PSYCHOLOGY ACT, 1991

LOI DE 1991 SUR LES PSYCHOLOGUES

The Chair: I call Bill 63, An Act respecting the regulation of the Profession of Psychology. In light of the agreement that has been reached, Mr Wilson, are you withdrawing your amendment?

Mr J. Wilson: Yes, Madam Chair.

Section/article 15:

The Chair: In that case, we are at section 15 and I call Mr Wessenger. I believe you have amendments to replace the ones you had originally tabled.

Mr Wessenger: Yes, that is correct.

The Chair: Withdrawing the old ones?

Mr Wessenger: Yes, I am withdrawing the old ones.

The Chair: Mr Wessenger moves that subsection 15(1) of the bill be struck out and the following substituted:

"(1) No person other than a member shall use the titles 'psychologist' or 'psychological associate,' a variation or abbreviation or an equivalent in another language.

And he further moves that subsection 15(2) of the bill be amended by adding after "psychologist" in the third and fourth lines "or psychological associate."

Mr Wessenger: If I might speak to the amendment, there has been a memorandum of agreement entered into between the MA psychologists and the practising existing psychologists with respect to the practice of psychology, which gives a status to the MA psychologists under the term "psychological associate," and this amendment is to recognize that memorandum of agreement.

Mr Owens: Just to gently correct the parliamentary assistant, this is not only a memorandum; this is a landmark memorandum of agreement. If applause were appropriate to this committee, I think we should all stand up and give the various associations a very loud round of applause for work well done.

Mr Wessenger: I would just like to add that I think the speed with which this agreement was concluded was very commendable. I wish we could all work that quickly.

Mr Beer: I would like to add my voice to that. When we began our discussions back in the summer and this issue arose, the various representatives went off to try to sort out an agreement, and it really is remarkable that they have been able to do it in such a short period of time.

This is one place in particular where we can all underline some real progress made, both in terms of protecting the public and expanding the opportunities for people to access services. Everybody involved had to really sit down and have a look at what they did and give and take. What has come out of that is something that is going to be, without any question, much better for our health care system. So I would want to say well done to all our friends here who were involved in that process.

Mr J. Wilson: Just briefly again, I commend the government on bringing forward the amendment and the associations involved, but rather than share credit with all

members of the committee I would like to particularly give credit to you, Madam Chair. You put a considerable amount of subtle, behind-the-scenes pressure on these people, and just for the record, when you decide to get something done, it is proof positive today that it gets done. Congratulations, because I know this predated this government. It is something that is long overdue, and I hope the agreement does not fall apart now that the legislation is going through. I trust all parties signed the agreement in good faith, and I look forward to further co-operation there.

Motion agreed to.

The Chair: Mr Wessenger moves that section 15 of the bill be amended by adding the following subsections:

"(2.1) A person who is not a member contravenes subsection (2) if he or she uses the words 'psychology' or 'psychological,' an abbreviation or an equivalent in another language in any title or designation or in any description of services offered or provided.

"(2.2) Subsections (1) and (2.1) do not apply to a person in the course of his or her employment by a university."

Mr Wessenger: This continues the protection that was continued in the former act. With the changes made with respect to the memorandum of agreement, I think it is an excellent amendment. It also provides for the exceptions with respect to those people employed as faculty of universities, which is essential for their protection.

Motion agreed to.

Section 15, as amended, agreed to.

L'article 15, modifié, est adopté.

The Chair: I think it might be appropriate at this time to clarify what has occurred regarding the profession of psychology. For those who are listening, what this agreement means and what the amendments that have been accepted today mean is that, for the first time, people with masters degrees, MAs, in psychology following this agreement will be considered professionals in the practice of psychology. That agreement was a result of the work done both by the existing board, which will soon become the college, as well as the associations of those who are presently regulated under the old legislation and those soon to be regulated.

Mr Wilson, I want to acknowledge what you have said. These discussions have been ongoing for 10 years. However, I believe that the people who are here today, the leaders of the professions, are the ones who are deserving of the praise, as they came together and worked very expeditiously to resolve problems that are professional in nature. As I call the bill, I think it is with acknowledgement of the significant progress that has been made in the practice of the profession of psychology and the access to services for the people of Ontario.

Shall Bill 63, as amended, carry? All those in favour? Any opposed? Carried. It will be ordered along with all of the other bills at the appropriate time.

The Chair: Any other business today that anyone can see on the agenda? In that case, the committee stands adjourned until 3:30 tomorrow afternoon when we will consider Bill 60.

The committee adjourned at 1618.

CONTENTS

Monday 4 November 1991

Regulated Health Professions Act, 1991, and companion legislation / Loi de 1991 sur les professions de la santé réglementées et les projets de loi qui l'accompagnent	S-913
Midwifery Act, 1991 / Loi de 1991 sur les sages-femmes	S-916
Psychology Act, 1991 / Loi de 1991 sur les psychologues	S-917

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Le mardi 5 novembre 1991

Standing committee on social development

Regulated Health
Professions Act, 1991
and companion legislation

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent



Chair: Elinor Caplan
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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 5 November 1991

The committee met at 1534 in room 151.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Suite de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

OPTOMETRY ACT, 1991

LOI DE 1991 SUR LES OPTOMÉTRISTES

The Chair: The standing committee on social development is now in session. We are dealing today with Bill 60, An Act respecting the regulation of the the Profession of Optometry. We have a number of motions which have been circulated today. We have dealt with all parts of this bill, except for the ones that are on the agenda.

Section/article 3:

The Chair: We will begin with section 3. I see first Mr Wessenger and a motion by the government, as well as a motion to be placed by Mr Wilson.

Mr Wessenger: There is a problem. I have not even seen the amendment yet that is proposed by the Conservatives.

The Chair: The clerk is distributing it now.

Mr Wessenger moves that section 3 of the bill be struck out and the following substituted:

"3. The practice of optometry is the assessment of the eye and vision system and the diagnosis, treatment and prevention of,

"(a) disorders of refraction;

"(b) sensory and oculomotor disorders and dysfunctions of the eye and vision system; and

"(c) prescribed diseases."

Mr Wessenger: Before I speak to the amendment, I wonder if there is an existing amendment on section 3.

The Chair: Are you withdrawing the amendment you had placed before?

Mr Wessenger: Yes, I withdraw the one placed before.

The effect of this amendment is to add a new class of authorized practice for the practice of optometry, and that is "prescribed diseases." What that in effect means is that the College of Optometrists of Ontario would have the right to pass regulations pertaining to designating the diseases it could diagnose. Those regulations would then, in the normal course, be circulated among all the health professions. It would then go to the Health Professions Regulatory Advisory Council for approval. If approved, the advisory council

would then submit it to the minister for approval in the normal course of regulatory procedure.

The Chair: Mr Wilson, I note you have an amendment which is quite similar. Do you want to amend the government's amendment, or are you placing a whole amendment of your own?

Mr J. Wilson: Yes, I would like to amend the government's amendment, particularly in view of what the parliamentary assistant has just said. My amendment would be that we add two words to the government's amendment in clause 3(c). Where the government's amendment reads "prescribed diseases," I would move that clause 3(c) be amended to read "diseases as prescribed in regulation."

The Chair: That is not just two words. What you will have to write out for us is that you are deleting "prescribed diseases" and inserting in its place under clause 3(c), "diseases as prescribed in regulation." Is that what you are moving?

Mr J. Wilson: Yes.

The Chair: Would you read that into the record and then your motion can be properly placed?

Mr J. Wilson: I move that clause 3(c) of the amendment be struck out and the following substituted:

"(c) diseases as prescribed in regulation."

The Chair: That would achieve your objective, I believe.

Mr J. Wilson: The purpose is to make sure that we are absolutely clear that the list of prescribed diseases will be set out in the regulations and dealt with by the advisory council. I see it as a very friendly amendment, and would hope that the government will support it.

The Chair: I notice there is another amendment to section 3.

Mr J. Wilson: I will be withdrawing our previous amendment.

The Chair: Mr Conway, how would you like to dispose of your amendment to section 3?

Mr Conway: It is Mr Beer's amendment, I believe. This is very confusing. I am just substituting here today. There are amendments being introduced and I am really in your hands. Our amendments have been postponed, I gather?

The Chair: That is correct.

Mr Conway: I am in the committee's hands.

The Chair: On behalf of Mr Beer, you can withdraw your amendment or you can allow the amendment to stand.

Mr Owens: Can we request a recess? We have just had this amendment dropped in front of us.

The Chair: We have had a request to recess for five minutes.

Mr Owens: I would suggest 10.

The Chair: We will recess and reconvene at 3:45 pm. Hopefully by that time you can decide how you are going to proceed on the amendment.

The committee recessed at 1540 pm.

1547

The Chair: The standing committee on social development is in session. For clarification as to process, we are going to deal with Mr Wilson's amendment to the amendment first; that is, the amendment to the government motion. I believe there was a minor clarification. Do you have it in front of you?

Mr J. Wilson: Yes.

The Chair: Mr Wilson moves that clause 3(c) of the amendment be struck out and the following substituted:

"(c) diseases as prescribed in the regulations."

That is the amendment to the government motion we are voting on now. Is there any discussion?

Mr Wessinger: I would like to oppose the amendment for the simple reason that this does not in any way change the effect from our resolution, which said "prescribed diseases." It makes no change in substance, so it is completely unnecessary to change this language, and also, the language proposed is inconsistent with the language contained elsewhere in the act. We should be consistent in our drafting. I have confidence in the drafting ability of our legal counsel and that they have used the right language. I take that as the proper way we should describe giving the college of optometrists the power to prescribe, by regulation, diseases.

Mr Owens: My question is to legislative counsel. The parliamentary assistant mentioned that it would be the college that would be doing the prescribing of diseases. Is that your interpretation of the language as it currently reads under the government amendment?

Mr Spakowski: The government amendment says "prescribed diseases." In my opinion, yes, "prescribed" there means "prescribed by regulations." The regulations referred to would be regulations made by the council of the college. "Prescribed" is defined in the code as prescribed by the regulations, and the regulation-making power is in the code to prescribe anything that is set out as prescribed.

Mr Owens: So the clause 3(c) currently being moved by Mr Wilson is redundant and serves no particular purpose—politically maybe it does—in terms of adding clarity to the language.

Mr Spakowski: I would say it has the same legal effect.

Mr Callahan: I think that is a nice way of phrasing it, but does it have the same practical effect? I would like to ask the parliamentary assistant: With simply putting the words "prescribed diseases" as finally proposed by the government, how does the mechanism start? What input do the professions being affected have to it to get it going? In the Conservative amendment they would have the opportunity to prepare a regulation and submit it to the cabinet regulations committee and would have some input into it. But without that, with just "prescribed diseases" they are left hanging out there. It may have the same legal effect. I

certainly would not want to dispute legislative counsel's interpretation, but the practical effect is that they are just hanging out there, and it could be left there for ever. They would be in the position they are in right now without this attempted amendment to mollify the situation.

Mr Wessinger: In my opinion there is no problem. We have the general bill, Bill 43, which all the professions are under. Under Bill 43, of course, we have the advisory council, and the regulation in this case would be made by the college of optometrists. Like other regulations, it must be reviewed by the ministry, and it will be referred by the ministry to the advisory council. These processes ensure that the government has independent policy advice and that optometrists, members of other professions and the public have the opportunity to comment on what is put forward by the college. The regulation is passed by the college and it goes through the process.

Mr Callahan: I understand from speaking with people who are involved in this that the minister has indicated that the way it would be triggered would be that the Ontario Medical Association and the college of optometrists would get together and try to negotiate what the prescribed diseases were. As I understand it, this process has been going on for a considerable period of time and we do not yet see any agreement reached, so how in the world do you expect that simply putting it in that fashion is going to change it? If, as legislative counsel has said, the amendment that has been read in by Mr Wilson has the same legal effect, what is the difference? Why can we not pass that and get on with it and stop squabbling?

Mr Wessinger: First of all, Mr Callahan, there has been a misapprehension with respect to the process by the optometrists. It is not a legal requirement that the optometrists and the OMA sit down and agree on a list. There was a suggestion made to the minister by the representatives of the optometrists, as I understand it, that the minister could assist in the meeting between the optometrists and the OMA. The minister, I understand, agreed to assist in such a meeting, but that has no legal aspect at all. It is purely a meeting at the request, by the way, of the optometrists. It was their request, not the request of the ministry.

Mr Callahan: I do not sit on this committee often, but I was here when the minister made her opening statement. She said she was going to listen to the people who came before her and that she was flexible and wanted the fullest representations from them. If the two of them are exactly the same, according to legislative counsel, in terms of their legal effect, why is it that the government prefers the clause (c) you are presenting, "prescribed diseases," as opposed to the one Mr Wilson has introduced as an amendment?

Mr Wessinger: That is a very easy question. When it comes to the drafting of legal language, I prefer the advice of lawyers to that of optometrists.

Mr Callahan: Just a second. Legislative counsel has told us quite clearly, and you said, and I would reaffirm, that the wording suggested in the government motion in clause (c) and that suggested in Mr Wilson's motion have the same legal effect. Is that correct?

Mr Spakowski: Yes.

Mr Callahan: All right. You have it from legal staff advising the committee that that is the case. Now can you tell me why you prefer one to the other?

Mr Wessenger: I think that is very simple.

Mr Callahan: I am simple, so explain it to me.

Mr Wessenger: The language put in the amendment is inconsistent with the language used elsewhere in the act. We are advised by legal counsel, and I think it only makes sense, to have consistent language throughout the act related to the professions and to the main legislation.

Mr Callahan: Where is it inconsistent?

The Chair: Mr Wilson, you have the floor.

Mr J. Wilson: I really do not have anything to add. I think Mr Callahan has made some excellent arguments and I do not think they have been refuted rationally or properly by the parliamentary assistant. I ask members in their heart of hearts and mind of minds to assess what you have just heard and support this amendment.

Mr Conway: I feel like a late arrival to a Benedictine monastery where I am in the midst of an elaborate vespers that I do not profess to understand in any detail. I am essentially here because a growing number of my constituents are increasingly concerned and have been on my case about this part of this multifaceted bill. I have heard what the minister said and I have heard what the parliamentary assistant said, and I am sure they offer it in good faith. My concern continues to be that the people for whom this is planned, to whom it is directed, have a much higher level of discomfort than apparently a lot of other providers do. I gather as well that there has been a not inconsiderable border clash between the government and the optometrists, about which border clash I pass no judgement. There is clearly some difficulty here.

I join Mr Callahan in making the observation that if people who are going to be affected are not comfortable and we are not going to redo this legislation for at least another generation or a half generation, then why would we not opt for the amendment that has been put by the member for Simcoe West, which appears to be more or less the same thing in terms of what legal counsel has analysed, but more important, gives some greater degree of comfort to a whole group of providers?

As I say, I am here just as the local member for Renfrew North. People in Deep River, Eganville and Pembroke have been phoning me, writing me and visiting me in the last few weeks to a quite considerable extent. They are really unhappy about what they think is going to happen. It is a long way to Ottawa to the neighbourhood ophthalmologist. A 72-year-old woman drove in the other day to tell me her tale and she asked me to come here and speak her piece and concern.

This is like a game of water polo. There is a lot more going on underneath the water line and I was not around for all that elaborate activity underneath the water line.

I think Mr Callahan has made a very good point. There is not a great deal of difference in the language in terms of its effect. If we are trying to assist the community in setting aside whatever tensions have existed between this government, perhaps even a previous government and the

optometrists, who I gather played this game rather more creatively than some others, why would we not accept an amendment that provides a greater degree of comfort to those providers, since it is clear that a very substantial number of people in that profession feel very strongly that the government's plan, however well intentioned, is in their minds a restriction on what they have been doing for lo these many years?

I reviewed the testimony of the delegation to this committee back in August of this year when those representatives from the college of optometrists were here talking about the capabilities of the men and women they are graduating from that school in Waterloo. As I say, there is a very high degree of concern and anxiety in the profession in my part of the province. It seems to me that if what we are being told is that there is not technically a great deal of difference, why would we not accept Mr Wilson's amendment, which appears to provide, to the profession at least, a higher degree of comfort? They do believe that what this bill will do in practical effect is limit what good works they do for people, in rural communities like mine particularly.

1600

Mr Owens: With respect to some of the comments Mr Conway has made, first of all, since the delegation appeared in August there have been some changes to the act, understanding that there were some levels of discomfort with respect to the definitions of certain words. The government side on the committee heard their concerns and brought forward changes to that. This is now the third generation of amendments. In terms of your comments around events happening below the water line, then you are correct. As I say, we are now into the third generation of amendments.

I think the operative point you make in your statement is that the optometrists are perhaps thinking what might happen in their own minds if we do not change the legislation to something that better fits their perceptions of what reality should be. I feel quite comfortable with the amendment the government has put forward with respect to prescribed diseases. I think legislative counsel has quite accurately pointed out that it will be the college of optometrists that will be in the business of prescribing which diseases optometrists will be in a position to diagnose.

In terms of some of the comments Mr Callahan made about people being left hanging or whatever the phrases were, the issue is covered quite nicely in the sense that the college is made up of optometrists as well as lay people who will address the concerns of the consumers as well as the professions, so there is going to be that kind of input. It is not going to be just simply an order in council that is passed by the government in terms of which diseases will be prescribed.

In terms of the border clash Mr Conway alludes to, I think the government has been more of a referee rather than an active participant between two parties and has been trying to do the best thing for all parties concerned. The bottom line is to do the best thing for the consumers of the product to ensure the access that you describe your constituent is concerned about, and also to add that measure

of protection that we have heard from time to time has been lacking in some of the professions.

Mr Conway: Can I just respond to one point? I may need some guidance in this.

The Chair: Mrs Witmer is next, but I will put you on the list, Mr Conway.

Mrs Witmer: I would agree with Mr Conway that there is a high degree of concern and anxiety about the amendments that are being discussed today. I live in a riding that has the only school of optometry in Ontario. I have been lobbied by the staff, the students and also by the optometrists in my own community. They are quite concerned with the legislation that is before us today. I believe it is extremely important that we consider their very legitimate concerns and provide the amendment they have recommended to us in order that they can feel comfortable.

They are the people who provide the service and I would agree that this amendment would certainly reinforce the purpose of self-regulation. I would hope the government would see fit to support this very friendly amendment.

Mr Conway: I just want to pick up on a point that the two previous speakers have made. The way I read these two propositions is that "diseases as prescribed in the regulations" would trigger a certain kind of procedural activity, whereas "prescribed diseases" refers that to a different kind of mechanism under this health disciplines legislation. If I am wrong in that, then I would be quite happy to be corrected.

Mr Wessinger: Since Mr Conway has asked the question, seeing he does not feel my explanation is clear enough, I will ask counsel to explain the procedure.

Ms Bohnen: "Prescribed" in "prescribed diseases" means exactly the same thing as "as prescribed in the regulations," and the mechanism for proposal and disposition of the regulations is identical. The council of the college of optometrists, after consultation with its members no doubt, will propose regulations listing the diseases. That regulation will come to the Ministry of Health, where it will be considered. It will be referred to the advisory council. Ultimately it will come back to the government for approval. There is no difference. The reason, I believe, that the government prefers the wording "prescribed diseases" is for consistency with how authority has been set out elsewhere in the act.

Mr Conway: I understand that, but I am not so sure you have not made the case again for Mr Wilson's amendment. As one of the members from the government said, you play the role of referee. In a sense that is what we do here. I am hearing one of the parties tell me that they do not view the language with the same degree of equanimity; quite the contrary. If they mean more or less the same thing—I do not know how many hundreds or thousands of optometrists we have; hundreds, I am sure, not thousands—

Ms Bohnen: Eight hundred.

Mr Callahan: Eight hundred and sixty-five, or something like that.

Mr Conway: Why would we not use language with which they feel more comfortable?

Mr Callahan: I would like to go back to that very point. I am from Missouri; you have to prove it to me. You

have told me, parliamentary assistant, that the reason the wording of the government motion is preferred over that of Mr Wilson's motion is that it fits in better with the wording of the act. Perhaps you can be good enough to show me where that is the case so I can make my own determination.

While you are doing that, I would like to address similar things that Mrs Witmer and Mr Conway have addressed. This is the section that perhaps will put this to bed. It is most important. I am new on this committee, but reviewing the Hansards from the past, it becomes quite apparent that if you are taking away something they have had since, I think, 1911, if you are in fact reducing accessibility for these people, you are affecting each and every one of your constituents, particularly in places like Sault Ste Marie and areas in the outlying districts where you will not have access to an ophthalmologist. You may have to travel considerable distances. We have all seen this in terms of delivery of health care to the people in the north. It had to be funded by the government to provide transportation to get people to those areas where they could get treatment.

You have heard it all, or those of you who have been around have heard it all, that you are denying access for your own constituents. Lo and behold, if this bill, when it is finally put to bed with all the appropriate amendments, does in fact do that you can be sure you are going to hear from your constituents.

I might add as well that I do not think it takes a rocket scientist. All you have to do is make an appointment with your local ophthalmologist to have your eyes examined and it can take up to six months. In some areas it is because they are very busy people. There are limited numbers. It also has something to do perhaps with the cap placed on them. I would not suggest that, but I imagine that may have some thrust in some areas.

You have to understand that, and if legislative counsel—and I do not want to attribute to him what you did, Mr Owens, that he said that would be as good as the other. My reading of it was that the two definitions are identical, that they have the same legal meaning. If that is the case, why are we sitting here splitting hairs? Let's get on with it. Let's make certain our constituents all over this fine province, natives—they are going to have a real problem. The government has indicated it has a great concern about the native population, and well it should. But if there is not something done to provide the services that can be done by optometrists to the people in the native communities, they are going to have to travel to an ophthalmologist, or they are going to have to do without that service.

They are going to get secondary health care, or it is going to be a question where the government, again, is going to have to provide transportation for these people and that can be difficult even if the funds are made available by your government, which I suggest would be very difficult during this time of recession. But let's talk about the weather of Ontario, where a person cannot be taken a long distance to have that matter dealt with.

I suggest we had best get on with it. Let's stop splitting hairs. If they are the same legal component, the government's and Mr Wilson's amendment, be magnanimous. Recognize

that this is an important issue to your constituents and all of our constituents. It is not a partisan issue; it is a matter of getting this very fine piece of legislation finalized, and we can do it in such a way that we hurt the fewest number of people and aid the most people. I urge the government members not to be straitjacketed by terminology when legislative counsel, who is paid an extraordinary fee to advise us in this regard—

1610

The Chair: I think legislative counsel is about ready to object.

Mr Callahan: —has told us there is absolutely no difference. That is why I say I am from Missouri, because I cannot believe the government would hold up this very important piece of legislation if they are, as legislative counsel said, identical in their legal meaning, unless there was some other purpose, and I want to know what that purpose is.

The Chair: I believe you almost provoked legislative counsel to take issue with the notion of exorbitant fees, Mr Callahan.

Mr Martin: I am not from Missouri; I am from Sault Ste Marie. I have been sitting in on these discussions since the beginning of this round and listened to all the folks who came forward and presented. We heard the same speech you just gave from the optometrists in August. We are very aware of all the things you have raised. We have raised them ourselves here and in other settings concerning access to service and all those kinds of things.

The present activity we are involved in is trying to find a place where we can all to some degree be comfortable, and I think we have. Indeed, when you talk about splitting hairs here, and that seems to be the issue at the moment, it seems to me the government brought forth an amendment that answered all the questions you raised a few minutes ago. The Conservative caucus has brought today to the table an amendment that begins the splitting-hair process. If "prescribed diseases" is consistent with what is in the bill already, why do we not just do that and get on with it if it means the same thing?

I would also like to suggest—or present, because I guess I feel like it—to you that all of this legislation is under debate by various professionals as we in Ontario try to sort out who can do what for whom, and it has been described by the minister in starting out this session as "living legislation." It is legislation that will be established today and changed in time to reflect reality and the delivery of health as it evolves in our province.

What we have here particularly, it seems to me, is a difference of opinion between two professional groups, and what we are doing here today is setting up an opportunity for those groups to come to terms ultimately with who does what. I am more than happy to put this issue to bed.

This government is not in any way getting in the way of this legislation moving forward. As a matter of fact we have been magnanimous, if that is the word the people are using, in bringing amendments to the bill and agreeing with amendments made by the Liberal Party. In this instance, I think it makes more sense to be consistent with what we

have already done than to introduce a new twist that means the same thing and is causing us to spend a whole lot of time this afternoon.

Mr Owens: With respect to the comments made by Mr Callahan, I am going to first of all take gentle exception with respect to native health care. This committee, this minister, the parliamentary assistant and all the folks who have been involved in the negotiation of this act and many other issues around this very important issue have dealt with this group with care, sensitivity and respect for their cultural needs.

If you had tuned in to the hearings yesterday, you would have noted that we passed an aboriginal midwifery section to the Midwifery Act which addresses the issue of aboriginal concerns. So I take exception to the comments with respect to natives. Coming from Scarborough, but having the same sense of scepticism a person coming from Missouri may have, you have made the—maybe allegation is too strong a word and if the chairperson thinks I should withdraw it, I will. However, you have said that—

The Chair: I have often cautioned members about the language they use, and if you feel that word may be provocative, you might choose another word.

Mr Owens: You have said that this bill, if passed as the government has proposed, will take away and reduce services to the communities. We have heard that, and when we have questioned how—even now in its third generation we come down to the "prescribed diseases" and "diseases prescribed in the regulations," I am asking, in a rhetorical sense of course, how the phrasing of "prescribed diseases" will reduce services to people in Ontario, your constituents and my constituents. The services will continue as they are now.

The issue of underserved areas within Ontario is a very serious issue and we understand that. It was a serious issue under your government and it was a serious issue under the government of the third party. We intend to take steps to address that issue. But launching into conversations that using the words "prescribed" and "regulations" will somehow address that issue is not appropriate. I hear what you are saying around let's move this on, and if you agree with the opinion of legislative counsel that there is no difference, then I suggest we move on and get this act passed.

Mr Callahan: First of all, I did not think I offended the native community. In fact, I was pleading their cause.

The Chair: Mr Callahan—

Mr Callahan: All right. I am not going to get into that, but I did want to find out something from the member for Sault Ste Marie. He said something very interesting: "This is a competition between two groups." I get the feeling that maybe he has more information than I do. But more important, I would like to know whether the trigger mechanism for setting up the prescribed diseases is identical under both wordings, and if that is the case then I await from counsel the reason, the rationale, the section by section, as to why the wording of the government's amendment is preferable for consistency purposes than that of Mr Wilson. I await that.

Mr Wessenger: I will have counsel enlighten you, Mr Callahan.

Ms Bohnen: I would like to begin by explaining to you why it is that we say "prescribed diseases" means diseases prescribed in regulations made by the College of Optometrists of Ontario. The word "prescribed" is defined in section 1 of the health professions procedural code to mean "prescribed in the regulations." "Regulations" is defined in subsection 2(2) of the Optometry Act to mean "the regulations under this act," the Optometry Act. Therefore, "prescribed" means diseases prescribed in the regulations under the Optometry Act. The process is, as you said, that the council of the college of optometrists initiates the process for these regulations.

Mr Callahan: Yes, but again, you indicated the government's wording is preferable to that of Mr Wilson because it is more consistent with the wording of Bill 60, and that is what I am asking you, to show me where it is inconsistent.

Ms Bohnen: Okay. The legislative package is dotted with references to things that will be done in the regulations and I tried, as I have been sitting here listening, to pick out a few of them. One example is an amended section to the Medicine Act dealing with the composition of the council of the College of Physicians and Surgeons. It is done in like manner throughout the other acts, and it says, "One person for each faculty of a university in Ontario selected in the prescribed manner." "Prescribed" means in the manner prescribed in the regulations. So we have tried to be consistent throughout all the bills, when we need to refer to something that will be prescribed in the regulations, to say "prescribed."

Mr Callahan: I am sorry. I am still at a loss to understand why the words "prescribed diseases"—I am a firm believer that you are going to make the legal profession rich and somebody is going to have to finally litigate, perhaps, the question of prescribed diseases. It is better to put it in there and be clear and say "diseases as prescribed in the regulations," then we all know what we are talking about.

The Chair: Are we ready for the vote on the amendment to the amendment? All those in favour of Mr Wilson's amendment to the amendment? Those opposed?

Motion negatived.

Mr Conway: What we will want to do, then, just for the sake of technical clarity, is that the Liberal amendments that were put by my colleague from York East, that deferred amendment on section 3, I would like to move that—

The Chair: I believe you have requested the clerk to frame that as an amendment to the amendment.

Mr Conway: That is correct.

The Chair: Would you like to take a five-minute recess so that can be framed?

Mr Conway: I think we are going to have to do it. Am I correct? Is that the way that would be done?

The Chair: You would withdraw this one and place your new amendment as an amendment to the government's motion.

Mr Conway: To the new government motion, yes.

Mr Hope: What are you amending?

Mr Conway: It is just that my colleague put a couple of motions down. The new government motion—

The Chair: Perhaps I can be helpful. Because the government's amendments, Mr Hope, were just received today, the amendments that had been proposed by Mr Beer and also by Mr Wilson before him, which were framed to fit with the government's amendments, now require some changes in light of the government's new amendments that have been tabled today. We have had requests from both Mr Wilson and Mr Conway to allow some time for reframing their amendments to the government's new motions. That is what has been requested. I think if we take five minutes, that can be resolved amicably.

Mr Hope: Whatever you think.

The Chair: The committee is in recess for five minutes.

The committee recessed at 1623.

1628

The Chair: We are dealing with section 3 of Bill 60.

Mr Conway moves that the amendment be amended by striking all the words after "prevention of" and substituting the following:

"(a) diseases and disorders of the eye; and,

"(b) sensory and oculomotor disorders and dysfunctions of the eye and vision system."

Mr Conway: I would simply like to reiterate some of what I have said earlier. My colleague Mr Beer had put this amendment earlier. It was set aside pending ongoing discussions. The argument I make in support of this is that there are a surprising number of optometrists with whom I have discussed this matter in recent weeks, albeit largely in my part of rural eastern Ontario, who, while they appreciate what the government is saying, feel that the government's intentions are not somehow going to be lived out in quite the way they are offered, and that this in fact is a restriction. It is a restriction that is going to compromise the self-regulatory aspect of their profession in a way that will provide a real difficulty to people living in rural Renfrew county who have, I think, only one ophthalmologist at their service and several optometrists who provide a front-line kind of care in all kinds of rural communities, some of which I have mentioned earlier. In my discussions with them, they felt that their interest and the public interest would be best served by the language that is before you in this amendment.

Mr Callahan: I would like to support the motion, and I presume the reason (c) has disappeared is that it is encompassed in (a), just for clarification purposes.

I want to go back to something that struck my eye when I was reading the Hansards. It was the question of the representative you had appear before you from Shibley, Righton in terms of having clear definitive terms of reference of what the optometrist could do and could not do. It was essential for a number of reasons. First of all, for disciplinary proceedings the parameters should be very clear. The secondary function was for legal liability, albeit, as I read the Hansards, there has not been an optometrist who has been called on the civil carpet over its lengthy years as a profession.

That was the thing that really attracted me, because in a very real sense this legislation, the entirety of it, was commenced with a view to being consumer legislation which was to define the product the public could expect to receive, and at the same time ensure the product was being provided in a sensitive and professional way. If that is the case, and I believe that to be the case, then it is absolutely essential that the governing body has the clarity of definition to be able to determine whether or not an individual practising in this field is doing it in such a way that he deserves not to be sanctioned, and in addition to that, that it be available to the public, that they can prove in a very definite way that this person has exceeded or gone beyond the bounds of his capability.

Of course leaving it the way it is proposed by the government, changing the parameters as suggested by the optometrists, really places those two issues in some lack of clarity. To go back to what I said before, if the purpose of this legislation was consumer-oriented, to try to define more clearly the parameters, then it has to be done in a much more significant way. I suggest that the motion that has been moved by my colleague from Renfrew North on behalf of Mr Beer goes a long way towards doing that. Again, not wanting to deprive any of my colleagues in the profession I belong to from being able to eke out a livelihood in terms of interpreting these things, I advance it notwithstanding.

The Chair: Is "eke out a livelihood" the opposite of exorbitant fees?

Mr Callahan: I said "eke out a livelihood" just like the Attorney General up there. He used to eke out a livelihood too.

The Chair: Sorry about that, Mr Callahan. I could not resist.

Mr Callahan: You say this is living legislation and that changes can be made. For heaven's sake, let's do it now at a time when we can benefit all those people out there in Ontario who are going to be denied accessibility to the person on whom you are granting a bequest of the full service of being able to have these people come to him for anything other than the fitting of lenses. I suggest these two sections here go a long way towards creating clarity, and the law should always be clear. I know the government members probably received some instruction on this and you do not want to interfere with that advice, nor would I try to persuade you to, but in the interest of all your constituents who are obviously watching this and who somewhere down the line—maybe not tomorrow, maybe not the next day, but next year, when seniors find they cannot get service promptly, when native populations find they cannot get service promptly, when a whole host of people throughout the province find they cannot get service promptly, they are going to be knocking on your door. If that happens in four years, you are safe, but if it happens before that, you are going to have grave difficulty, because you are going to have to answer those problems. I urge you to support this amendment to the amendment.

Mr Wessenger: I would like to speak against the amendment, because what the amendment does is allow

optometrists to diagnose all diseases and disorders of the eye. In fact, optometrists do not diagnose all diseases and disorders of the eye. They will admit that. In effect they do admit it by accepting the "disorders of refraction."

If we look at what they were willing to accept, they were willing to accept basically the government amendment. We had a slight disagreement with respect to the matter of "prescribed diseases" or "diseases as set out in the regulations." However, that was just a misunderstanding on their part with respect to the meaning of the language and I understand they have now accepted that.

This would leave it wide open, and in fact optometrists do not do that and the intent of this legislation is to give to optometrists what they actually do.

As far as the whole question of clarity goes, the term "disorders of refraction" is a term that is set out to describe eye disorders by the World Health Organization in the Manual of International Statistic Classification of Diseases, Injuries and Causes of Death. Under "disorders of refraction" they list certain types of disorders; that is, hypermetropia, myopia, astigmatism, anisometropia and aniseikonia, presbyopia and disorders of accommodation. I understand this is basically one of the disorders that optometrists identify from their examinations.

I might add that the government amendment recognizes optometrists as diagnosing considerably more than was recognized by the Health Professions Legislation Review. If we look at the description of the practice of optometry contained in legislation in other provinces, the scope of practice described here is basically broader than that in other provinces, which do not give the wide-open power of diagnosis to the optometrists.

In addition to diagnosing specified diseases, disorders and dysfunctions, which they will be doing, optometrists are recognized as assessing the whole eye and vision system. Therefore, limitations on what they may diagnose in no way prevents them from recognizing or detecting the signs of other conditions, monitoring their patients and making referrals when necessary.

I would like to refer to a couple of instances that have been raised as of some concern by the optometrists. In submissions to the committee, the association said it would be prevented from diagnosis of cataract, monitoring its development, providing for changes in the patient's visual needs, counselling and referring patients when necessary. Not so. Optometrists may lawfully continue to assess eyes, detect symptoms of cataract, monitor the patient and make referrals when necessary.

Also, with respect to the whole question of glaucoma testing, under the legislation the optometrists will continue to be able to do glaucoma testing, to communicate the results of those tests to the patient and, where the tests show the glaucoma situation, to refer them to ophthalmologists, which they presently do.

Mr J. Wilson: Just very briefly, because I have to go in the House—I am the next speaker up, I believe, after Mrs Sullivan.

Mr Owens: Trashing medicare.

Mr J. Wilson: It is a very important bill.

We will be supporting the Liberal amendment for the simple reason that, since our amendment has just been defeated, we think this is the second-best option. The word "refraction" is something that very much disturbs us in the government's amendment in the final analysis, and something we have heard from optometrists disturbs them also. So we will be supporting the Liberal amendment. I think it is the second-best option, given that ours has already been defeated, and I congratulate the Liberal members for coming forward with it and putting forward what I think to date has been a very good argument in support of the amendment.

1640

Mr Callahan: I want to clear something up the parliamentary assistant said. He said that optometrists will now, if they see something in the eye—which is the window of your soul, by the way, if you did not know that—be able to refer it to an ophthalmologist. It is my understanding from reading through the Hansards that if they see something, they cannot tell the person he has it. They can simply refer them to an ophthalmologist, at the expense of OHIP, at a time, or prematurely perhaps, in the case of cataracts, where before they could have watched it, kept an eye on it—I am not attempting to be funny there—and then at the appropriate time referred it to the medical profession, the ophthalmologist, for treatment.

I thought I heard you say they could deal with all these things you listed. I am not going to attempt to even put my mouth around them because they are as bad as some legal phrases, but that is not until the prescribed diseases are triggered by whatever the mechanism is that triggers them. Between now and the time they are triggered, in fact what the optometrists have to do is look into a person's eye and say: "There's something wrong there, but I can't tell you because that's outside the scope of my authority under this act presented by the government. I'll refer you to ophthalmologist A. You can get an appointment with him six months from now and he can tell you. If I'm wrong, then come back and we'll continue the procedure."

If I am wrong in that regard, please tell me, because if prescribed diseases have already been catalogued in some government regulation, I would like to know what it is. I think the optometrists would like to know that too.

Mr Wessenger: The diseases I listed are described as "disorders of refraction," and those types of diseases will not have to be mentioned as "prescribed diseases" because they are already covered under the definition "disorders of refraction," so it will be completely unnecessary for those to be set out under "prescribed diseases." It would only be diseases or disorders that do not fall under the category "disorders of refraction" that would have to be set out under "prescribed diseases." So "prescribed diseases" is an addition, not an inclusive situation. It is in addition to what is set out in "disorders of refraction," as well as an addition to what was set out in clause (b) as well, "sensory and oculomotor disorders and dysfunctions of the eye and vision system."

Mr Callahan: Where is that prescribed? Where is that set out in law?

Mr Wessenger: It is set out in section 3, "The practice of optometry is the assessment of the eye and vision system and the diagnosis, treatment and"—

Mr Callahan: I can read that, but where are those listed?

Mr Wessenger: Those are listed under the list of diseases by the World Health Organization.

Mr Callahan: What has that got to do with the legislation in Ontario?

Mr Wessenger: It is recognized by the World Health Organization as being a disorder of refraction. I am sure the court would accept what the World Health Organization defines as a disorder of refraction.

The Chair: Perhaps I could be a little helpful. What the parliamentary assistant has pointed out is that in the government's amendment under clause (a), "disorders of refraction" means—he has listed what that actually means. As I understand it, that is accepted practice, because it is a definition from the World Health Organization. Is that correct, Mr Wessenger?

Mr Wessenger: That is correct. Thank you, Madam Chair.

Mr Callahan: So these people can use this Hansard some day if they are prosecuted for that and say, "That's what we were told by the parliamentary assistant, that the World Health Organization's definition should be used." I would find that little comfort, but thank you.

The Chair: We are ready for the vote.

Mr Conway: A recorded vote.

The committee divided on Mr Conway's motion, which was negatived on the following vote:

Ayes—3

Callahan, Conway, Witmer.

Nays—6

Haeck, Hope, Martin, Owens, Ward, Wessenger.

The Chair: We now move to Mr Wessenger's amendment. This is the government amendment, the main amendment as moved by Mr Wessenger. Are we ready for the vote?

Mr Conway: I would like to make a comment on that very briefly. I cannot see myself supporting this, simply because while I recognize that the government has moved, I continue to be troubled by the fact that the people who are expected to deliver this service that it is almost a wilful restriction of what they have been doing. As a referee, that gives me a great deal of discomfort. While I appreciate what the government has done, I do not think it is clear enough and I do not think it is satisfying enough and I—

Mr Callahan: I also share your concern.

Mr Conway: My colleague the member for Brampton South tells me he shares my concern as well. It is for that reason I cannot support the main motion which will be put presently.

Mr Wessenger: If I might put it on the record, I have something here that is written from the optometrists. It says, "In response to the government's proposed amendment of

November 4, 1991, the Ontario Association of Optometrists, representing the profession of optometry, proposes the following amendments to the government amendments." It says:

"Scope of practice and authorized acts: Scope of practice:

"3. The practice of optometry is the assessment of the eye and vision system and the diagnosis, treatment and prevention of,

"(a) disorders of refraction;

"(b) sensory and oculomotor disorders and dysfunctions of the eye and vision system; and

"(c) diseases as prescribed in the regulations."

This is exactly the same as the government motion except for using "prescribed diseases," which means the same thing as "diseases as prescribed in the regulations." This is what has been requested by the OAO. That is all I would like to put on the record.

Mr Conway: I would just respond to that by saying I think that is disingenuous.

The Chair: I will put you on the list, Mr Conway. Mr Martin.

Mr Martin: I have heard the member for Renfrew North today speak very seriously and sincerely about his concern re his constituents and the folks who came to his office. I heard Mr Callahan as well speak rather eloquently about his concern re the delivery of service. I assure you that having sat on this committee from the beginning of this go-round, I also—actually all of us on this side—have listened to a lot of our constituents and we have listened to the optometrists as they have come. We listened to them seriously and many times over the last number of weeks, and particularly in the last week or two.

We have indeed had instruction—instruction from them, instruction from legal counsel that is made available to us, instruction from each other as we have discussed this—and we tried to come up with something that would reflect a genuine concern by us about those very things you across the room spoke of so eloquently today. In my heart of hearts, I think we have come up with what at this point in time we think is the best amendment. As I said before, this is not perfect. None of this legislation is what you would call perfect, but it is a good beginning. It is living legislation and it will evolve.

The delivery of health care in this province at this point in time is certainly not perfect, but I think in time, with the kind of discussion we have had here at this table and the discussion that will go on across the province, we will arrive at a place where it will be a little more perfect than it is today. I support the amendment today re this act, and support it having had instruction by many people around it. I know that at this point in time it is the best thing we can do.

Mr Owens: I think the OAO has spoken quite eloquently to my point with respect to the kinds of amendments it would like to see in this piece of legislation. I agree with the point Mr Martin has made, that we have listened quite closely and quite considerably to a number of deputations, whether it has been on the committee or in our constituency offices or in the hallways of the House. It

is not without some difficulty that we have come to this resolution, but it has been done in partnership with the optometrists and their associations.

1650

There have been comments around when prosecution of optometrists for doing as they have done for many years will take place. I am not sure who is going to launch those prosecutions and why optometrists feel they are going to be prosecuted for doing the good work, the excellent work they have done for many generations. There is no dispute that this legislation does not prohibit that fine work from continuing.

Mr Callahan: Finally, it is my understanding—I may be incorrect—that there has been a more recent release than that which is being read by the parliamentary assistant, or a more recent feeling than what has been read by the parliamentary assistant, and our rules, because of this being clause-by-clause, do not allow those people to come forward and perhaps correct that record. To the member for Sault Ste Marie, I hope you are right. I somehow have doubts, but I hope you are right. If you are not, I am sure the people of this province will be back to tell us that you were not right and that in fact they are being denied access to services that heretofore, since 1911 or whenever, 1919, they had been receiving.

The committee divided on Mr Wessenger's motion, which was agreed to on the following vote:

Ayes—6

Haeck, Hope, Martin, Owens, Ward, Wessenger.

Nays—3

Callahan, Conway, Witmer.

Section/article 4:

The Chair: We are now on section 4. We have a government motion first. We have an amendment by Mr Wilson. Are you going to be moving it, Mrs Witmer?

Mrs Witmer: I will be.

The Chair: There is a further amendment by Mr Conway. The clerk has advised me that the order of procedure is that Mr Wessenger's motion should be placed first, Mr Conway's would be an amendment to the government's motion, then Mrs Witmer or Mr Wilson's motion would go next.

Mr Wessenger moves that paragraph 1 of section 4 of the bill be struck out and the following substituted:

"1. Communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system or a prescribed disease."

He further moves that section 4 of the bill be amended by adding the following paragraph:

"1.1. Applying or ordering the application of a prescribed form of energy."

Mr Conway's amendment is next.

Mr Conway moves that the government motion amending section 4 of the bill be amended by striking out paragraph 1 set out in the motion and substituting the following:

"1. Communicating a diagnosis identifying, as the cause of a person's symptoms, a disease or disorder of the

eye or a sensory or oculomotor disorder of the eye or vision system."

You have withdrawn on behalf of Mr Beer's previous motion. We are speaking first to Mr Conway's amendment to the amendment. All those in favour of Mr Conway's amendment to the amendment? Those opposed?

Motion negatived.

The Chair: Mrs Witmer moves that section 4 of the bill be struck out and the following substituted:

"4. In the course of engaging in the practice of optometry, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

"1. Communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction or a sensory or oculomotor disorder of the eye or vision system or a disease as prescribed in the regulations.

"2. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses.

"3. Performing a procedure in the surface of the cornea.

"4. Applying a prescribed form of energy.

"5. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response."

Mr Wessinger: I would like to speak against certain provisions of the amendment. First, in paragraph 1, it is the same language as our provisions except it refers to "prescribed by the College of Optometry of Ontario." It is unnecessary to have that language in. It is inconsistent and also it is incorrect, as it is the College of Optometrists of Ontario rather than the College of Optometry of Ontario.

Second, with respect to paragraph 3, we would oppose that because that would authorize optometrists to perform surgery on the eye, and they certainly are not qualified to do that.

With respect to paragraph 4, I have no particular objection to it. If they want to change their amendment to do that, we could certainly accept paragraph 4.

On paragraph 5, again we are in opposition to that because the optometrists are not involved in allergy testing, but they are involved in the care of contact lens patients. They deal with the question of products which may induce allergic responses, but they do not do allergy testing.

Mrs Witmer: I would like to respond to Mr Wessinger and also make a correction. In my amendment I did not say "as prescribed by the College of Optometry of Ontario." I said "as prescribed in the regulations."

Mr Wessinger: Oh, you changed that part.

Mrs Witmer: That was changed, Mr Wessinger.

Mr Wessinger: Okay. The draft I had—I am sorry.

Mrs Witmer: That is fine. I just wanted to correct the record, and I would like to speak to the amendment as well.

Mr Conway: On a point of order, Madam Chair: I have to leave to go upstairs to join the other health debate. I just want the record to show that I left not because I was not enjoying this debate and did not want to cast a final vote, but I cannot miss this—

Interjections.

Mr Conway: Bill 135 calls. I apologize.

Mrs Witmer: I have visited the school of optometry and had many discussions with the professionals there and with the other professionals in my community. After much discussion, we put forward this amendment because we feel it more appropriately describes the scope of practice for the optometrists and more accurately reflects the work they do. I also think we have to keep in mind that there has not been, in the past 10 years, any real proof of harm to patients from optometrists, and there is certainly no evidence that would support the restriction of the optometrists' scope of practice or performing any of these acts.

I also think we have to remember—certainly my visit to the school of optometry at the University of Waterloo bore this out—that optometrists today are very highly educated and trained. In fact, the senate committee at the University of Waterloo reported that the training program "is taught at levels of sophistication that are comparable to science and medical students."

1700

I would also like to point out to you that full eligibility has been accorded to the school of optometry by the Medical Research Council in 1991. I would like to quote again where it says: "We recommend that schools of optometry be recognized as science-based health professional schools with a proven place in research in the science of vision, and that they be accorded full eligibility for the programs of the Medical Research Council."

There have been changes in the past few years, and I would like to stress again that these people are highly educated and trained professionals. I think we have to recognize the scope of practice and the actual work they are doing at the present time because of the training they are receiving. I have been most impressed with what is going on.

Mr Callahan: We will be supporting this amendment. I think it passing strange, in my reading of the Hansards, that in the United States—the country we all seem to emulate and think is so progressive and far ahead of us—they go even further than this. They must trust their professional people in optometry down there to a much larger degree because, as I recall, they allow them to administer medication.

When you look at the ever-increasing costs to our health care and the magnificent health care we have, and wanting to maintain it and not get into the US scenario where to become ill could result in your becoming a section 11 or a bankrupt, we are moving—hopefully not, but it looks like we will be moving—in that direction of adding a further burden to our health care costs. At the same time we will be depriving the community of those services my colleague has just indicated have never resulted in any type of action for inappropriate steps. Apparently it is very well governed by its governing body. I would imagine that is the case. The people are highly professional. One year of science training along with four years, which is an honours degree in university, certainly makes me feel comfortable with the fact that these people are highly professional.

I suggest that the motion moved by my colleague is one that not only will assist the people of Ontario in terms of having accessibility to services they will need—particularly seniors as they get older; this is a very important service to

them—but I would certainly hope we would become progressive, perhaps not to the extent of the United States, because we really do not know what their qualifications are down there or whether they are at the high standards our people in this province are at.

I think the amendment that has been put forward is like a vote of confidence in these people who have served this province well since 1919 and who since 1960 been governed by a body, which has resulted in no inappropriate actions to any member of the public. I think the public considers them to be highly trained and highly professional. I urge the members of the government to support this and to ensure that all those things I have addressed do not come to pass.

Mr Wessenger: I would like to respond by saying this legislation in no way restricts what optometrists now do. It does not restrict them in their existing scope of practice. It will still be in the title to do exactly everything they do now. It will not in any way reduce accessibility.

With respect to the whole question of cost, it is kind of interesting. I have the fees in front of me with respect to ophthalmologists and optometrists. For an assessment, the fee paid to an optometrist is \$39.15. The fee paid to an ophthalmologist is \$38.40, which is less than that paid to an optometrist. For a reassessment by an optometrist it is \$19.25, and for a partial assessment by an ophthalmologist it is \$19. The interesting aspect is that although the fees are supposed to be relatively the same, at the moment the optometry fees are higher than the ophthalmology fees.

Mr Callahan: I am sorry; I missed that. What do you mean by that?

Mr Wessenger: The allegation has been made that it is going to increase the cost.

Mr Callahan: Well, it is if you have to refer them to—

The Chair: Mr Callahan, you do not have the floor.

Mr Callahan: All right; I was just going to say—

The Chair: You do not have the floor. Mr Wessenger?

Mr Wessenger: With that I will conclude my remarks.

The Chair: Are we ready for the motion? Any further amendments? All those in favour of Mrs Witmer's amendment to the amendment?

The committee divided on Mrs Witmer's motion, which was negated on the following vote:

Ayes—2

Callahan, Witmer.

Nays—5

Haeck, Martin, Owens, Ward, Wessenger.

Mr Wessenger: With the consent of the committee, I wonder if it might be possible, with respect to paragraph 4 moved by the Conservatives, to substitute that for paragraph 1.1. I know it will require unanimous consent.

The Chair: Do do you want to withdraw your amendment and read in to the record what you would like to do?

Mr Wessenger: Yes, if that would be satisfactory.

Mr Callahan: On a point of order, Madam Chair: That has already been defeated.

The Chair: No, that is permitted. Mr Wessenger's motion is now on the table. Mr Wessenger is withdrawing his amendment and will read in his new amendment and provide it in writing.

Mr Callahan: But Madam Chair, the paragraph he is trying to impose has already been defeated.

The Chair: What Mr Wessenger is doing, Mr Callahan, is making a change to the amendment he has tabled, using some of the wording that was in Mrs Witmer's amendment.

Mr Callahan: He is not using the exact wording?

The Chair: He will read it into the record and it will be clear.

Mr Wessenger: I move that paragraph 1 of section 4 of the bill be struck out and the following substituted:

"1. Communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system or a prescribed disease."

I further move that section 4 of the bill be amended by adding the following paragraph:

"1.1 Applying a prescribed form of energy."

Mr Callahan: Where does that change it?

The Chair: Mr Wessenger's original amendment, stated under 1.1 and written before you, reads: "Applying or ordering the application of a prescribed form of energy." With the change he has just made to his amendment, 1.1 now reads, "Applying a prescribed form of energy." That is his new motion. All right? Clear?

Mr Callahan: That is my point of order. That has already been voted on and defeated.

The Chair: That is not correct. Mrs Witmer's entire amendment was defeated. Mr Wessenger is placing his amendment and it is in order. Are there any speakers to Mr Wessenger's amendment? Are we ready for the vote? All those in favour of the amendment? Any opposed?

Motion agreed to.

The Chair: What I would like to do now, on both section 3 and section 4, is to call for the sections. Shall section 3, as amended, carry? All those in favour? Any opposed?

Section 3, as amended, agreed to.

L'article 3, modifié, est adopté.

The Chair: Shall section 4, as amended, carry? All those in favour? Any opposed?

Section 4, as amended, agreed to.

L'article 4, modifié, est adopté.

Title agreed to.

Le titre est adopté.

The Chair: Shall the bill, as amended, carry? All those in favour? Any opposed? Carried.

Now we have to order all of the bills. Shall I report Bills 43 to 64, inclusive, as amended, on Thursday, November 7, 1991, to the Legislature? All those in favour? Any opposed?

Mr Callahan: I was going to ask, to be consistent, in light of the fact that we voted against Bill 60, that we have that extracted for purposes of reporting.

The Chair: All right. Shall bills 43, 44, 45, 46—

Mr Callahan: You do not have to do that.

The Chair: How else do you want to do it?

Mr Callahan: You can simply say Bill 43 through Bill 64, with the exception of Bill 60, shall be reported to the House. That would be an easy way of doing it.

The Chair: No. How about if we just do them all? All right.

Mr Callahan: All right.

The Chair: You can vote against ordering them if you do not like it. Shall I report bills 43 to 64, inclusive, as amended, on Thursday, November 7, 1991, to the Legislature? All those in favour? Any opposed?

Bills 43 to 64, inclusive, as amended, ordered to be reported.

Les projets de loi 43 à 64, inclusivement, modifiés, devront faire l'objet d'un rapport.

The Chair: Thank you all very much. We have completed a very significant package of bills with what I think is a kind of spirit at this committee which has been most productive on most occasions.

The committee adjourned at 1712.

CONTENTS

Tuesday 5 November 1991

Regulated Health Professions Act, 1991 , and companion legislation / Loi de 1991 sur les professions de la santé réglementées et les projets de loi qui l'accompagnent	S-919
Optometry Act, 1991 / Loi de 1991 sur les optométristes	S-919

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

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Première session, 35^e législature

Journal des débats (Hansard)

Le lundi 2 décembre 1991

Standing committee on social development

Ontario Medical Association
Dues Act, 1991

Comité permanent des affaires sociales

Loi de 1991 sur les cotisations
de l'Ontario Medical Association



Chair: Elinor Caplan
Clerk: Lynn Mellor

Présidente : Elinor Caplan
Greffière : Lynn Mellor

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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 2 December 1991

The committee met at 1537 in room 151.

ELECTION OF VICE-CHAIR

The Chair: The first item of business for today is the election of Vice-Chair of the committee. Honourable members, may I have the names for the election of Vice-Chair?

Mrs Sullivan: I move that Mr John Sola be appointed Vice-Chair of the committee.

The Chair: Are there any further nominations? There being no further nominations, I declare the nominations closed and Mr Sola elected Vice-Chair. Congratulations, Mr Sola.

SUBCOMMITTEE REPORT

The Chair: The second item today is the report of the business subcommittee concerning Bill 135. The clerk has distributed it and everybody should have it. I would like to report to the committee that I have had a request from one other group that is not listed here on the subcommittee's report.

There are two ways of handling this. We can, one, have an amendment to the subcommittee's report permitting the Chairman to substitute in, time permitting, or, two, unanimous consent from the committee to allow for a further presentation, which could take place at 5 pm. Mr Sola, which of the two options do you prefer?

Mr Sola: The second.

The Chair: Is there unanimous consent for one further deputation before the committee at 5 pm today? All agreed? Agreed. In that case, will we as well receive the report of the subcommittee as amended? All in favour? Any opposed? Carried.

Mr Wessenger: I assume there is no reason we cannot have Mr LeBlanc at the table.

The Chair: No, I am sure everybody would be very happy to have Mr LeBlanc come to the table. Do you want to introduce him so that everybody knows who he is?

Mr Wessenger: Yes. This is Dr Eugene LeBlanc. Eugene, you might introduce yourself.

The Chair: What is your title today, Eugene?

Dr LeBlanc: I guess I am still technically the executive director of corporate policy, but for the last six or seven months I have been worrying about the Ontario Medical Association agreement.

ONTARIO MEDICAL ASSOCIATION DUES ACT, 1991

LOI DE 1991 SUR LES COTISATIONS DE L'ONTARIO MEDICAL ASSOCIATION

Resuming consideration of Bill 135, An Act to provide for the Payment of Physicians' Dues and Other Amounts to the Ontario Medical Association / Loi prévoyant le paiement des cotisations des médecins et d'autres montants à l'Ontario Medical Association.

ONTARIO CONFEDERATION OF UNIVERSITY FACULTY ASSOCIATIONS

The Chair: The first presenter is the Ontario Confederation of University Faculty Associations, sometimes referred to as OCUFA. I would ask you to introduce yourselves to the committee, all four with your titles. You have half an hour for your presentation and we would ask you to leave a few minutes at the end so that committee members may ask questions.

Ms Perrin: My name is Marion Perrin. I am the executive director of OCUFA and I will introduce the people at the table with me. Professor Dan Geagan is from McMaster University. Professor Mike Dawes is from the University of Western Ontario Faculty Association. Representing the University of Toronto Faculty Association is Allison Hudgins.

OCUFA is pleased to have the opportunity to appear before the standing committee on social development to address our concerns with respect to Bill 135. We would like to state at the outset that we applaud the government's attempts to contain burgeoning health care costs and that we support the concept of collective bargaining for the province's physicians.

Bill 135 is, as you are aware, the Rand legislation the government undertook to introduce pursuant to article 4 of the framework agreement between itself and the Ontario Medical Association. We do not oppose the introduction of the Rand formula with respect to the province's physicians, but we do have concerns with respect to its application.

There are legally constituted faculty bargaining units at the five universities with medical schools in the province which represent physicians, as defined in the agreement between the government and the OMA and as reflected in Bill 135. In some quarters, this agreement/legislation has been called an illegal raid of faculty bargaining units.

It is no doubt obvious that local faculty associations are concerned about the erosion of their bargaining power, particularly with respect to policy and academic issues. In two cases at least, there could be a significant loss of membership. The bargaining units affected are McMaster University Faculty Association, the Association of the Professors of the University of Ottawa, Queen's University Faculty Association, the University of Toronto Faculty Association and the University of Western Ontario Faculty Association.

The agreement provides for representation of all practising physicians in Ontario by the OMA. The definition of who the OMA represents in the agreement and in Bill 135 is very broad indeed. In the agreement, a practising physician is defined as including those who provide "health care, health services or health research to or for the benefit of individuals or the community." Subsection 1(1) of Bill 135 makes it clear the OMA is to receive dues from all

licensed physicians "engaged in the practice of medicine in Ontario or who conduct health research in Ontario."

Pursuant to the agreement, to obtain bargaining rights or representation rights for physicians in the university sector, the OMA serves notice to bargain. After notice to bargain has been given by the OMA, the employing agency or a member of the unit being claimed may challenge the OMA to demonstrate that it actually represents those physicians. Where the OMA demonstrates it has more than 50% membership in the unit, it may bargain on compensation, matters affecting compensation or other matters agreed to by the parties. If no agreement is reached, they have the right to go to mediation and arbitration.

These provisions have been called democratic. We wish to make two points with respect to that comment.

1. It is not surprising that a large number of physicians are presently OMA members, thereby making proof of membership for representation quite easy. The OMA is the primary professional and/or educational body of physicians in Ontario.

2. The provisions under the agreement whereby the OMA proves its membership for bargaining purposes are generous in comparison to the Ontario Labour Relations Act. Under that act, proving membership and gaining representation rights is a long and sometimes painful process for unions. Notice to bargain cannot be given prior to the union proving sufficient membership desire for that particular union to represent it for the purpose of collective bargaining. Perhaps the government will extend quicker and easier organizing and certification procedures to all workers in the near future.

The situation on each of the five campuses varies dramatically. These are complex situations which can only be handled on a local basis. Four of the five bargaining units represent clinicians to some extent. There is a range of physicians' duties as professors on each campus, from those who do only research, those who do research and teach, those who have cross-appointments with hospitals and universities, to those who teach as clinicians on an occasional or part-time basis. In medicine, like law and business, a very large number of professionals teach on a part-time basis, for a variety of reasons, including prestige.

Faculty association bargaining units have traditionally represented faculty on a wide range of issues, including promotion and tenure. Generally, clinicians receive the same treatment under promotion policies, although tenure may not be applicable. Faculty also bargain for salaries and benefits, leaves of absence, including sabbatical and other educational leaves, and a wide range of academic concerns. Life in academe goes far beyond simply negotiating for salaries. Faculty associations have developed considerable expertise in these matters, particularly academic matters at the local level, and have access to expert advice from both their provincial and federal bodies.

Physician professors work alongside other university faculty within university and hospital research settings, as well as in health care settings. This illustrates one of the reasons OCUFA has proposed that the local faculty associations and the OMA work jointly in representing university physician professors.

The Association of Professors of the University of Ottawa has formally negotiated a series of collective agreements with the university administration since certification in September 1975. The recognition clause of their agreement excludes clinicians. They clearly represent physician health researchers. However, in their view, efforts by the OMA to represent the health researcher members of APUO in any matter, and assuming of course that the administration acceded to such a request, would be a breach of their collective agreement and could potentially lead to bad-faith bargaining charges before the Ontario Labour Relations Board. In addition, any impingement on negotiating, other than compensation matters for clinicians, which would affect all faculty, would be considered a breach of their collective agreement as well.

The University of Toronto Faculty Association has negotiated a series of agreements with the university administration since the signing of its memorandum of agreement in June 1977. Their memorandum covers all faculty members and librarians. Similar to the other faculty associations, policy and academic issues as well as salary and benefits are subject to negotiations with the faculty association.

The University of Western Ontario Faculty Association has been informally negotiating on behalf of faculty with the university administration since 1971. The bargaining relationship was formalized in April 1985. Their most recent agreement is for the period 1990-93. They, like the other faculty associations, also represent faculty in grievance process.

1550

In September 1976 the bargaining relationship at Queen's between the administration and Queen's University Faculty Association was formalized. Prior to this time, bargaining on salaries had taken place since the 1960s. QUFA is most concerned that academic and policy issues continue to be determined in the traditional manner; that is, between the faculty association and administration.

The McMaster University Faculty Association has been in existence since 1951 and has been engaged in bargaining with the administration of the university since 1973, prior to a formalization of the relationship in 1984. The faculty association has representation on all committees in the university. Since counsel for the OMA also represented McMaster in its pension dispute with the university administration, it may be assumed he is well aware of its status. In addition, there have been negotiations between the McMaster faculty association and the clinical group at McMaster along the lines we suggest take place at each university affected by the OMA agreement and Bill 135.

OCUFA suggests the negotiation of jurisdictional issues and membership fees and issues be local in nature, due to the wide variation of circumstances at each of the universities. We are not seeking to replace the OMA in its role of negotiating fees for clinicians; that is, fee for service or a new alternative payment plan. We do, however, seek the right to retain the traditional role faculty associations have had and continue to have in representing all faculty with respect to academic and policy issues.

We agree with the Honourable Ed Philip, who said that people "have to pay for a service (they) are getting. Surely that makes sense. Why should someone get a free ride when others are paying?" Physician-professors should pay for the benefits that local faculty associations negotiate for them and for all faculty.

We are not interested in the potential litigation that could result due to the agreement and Bill 135. We are interested in working with the OMA for a productive labour relations climate for the benefit of all members of the university community.

As part of my concluding paragraph, I would like to point out an attachment from McMaster University. President Ed Daniel from McMaster was unable to be with us today. He has outlined where they are in their negotiations with the McMaster clinical group at this time. It is quite a productive process and that is what we foresee on each of the campuses.

We request members of this committee to put forward the following amendment to Bill 135:

"1(3) This act does not apply to individuals represented by faculty bargaining units in Ontario universities, except where the individual faculty bargaining units and the Ontario Medical Association have reached agreement on jurisdictional and membership issues."

In addition, late last week we proposed to the OMA that there be included in an agreement between us a dispute resolution clause at the local level to ensure that there are no untied ends in this matter. I would now like to ask Dan Gegan from McMaster to say some words.

Mr Gegan: Ed Daniel, our president, is not able to be here today—he is employed full-time in the medical centre as part of the medical faculty—nor is Frank Baillie, the president of the clinical faculty association. So I come as the McMaster member of the OCUFA board of directors.

These remarks are additional to the letter that is included and are not in any of the packets. McMaster has both a faculty association and a clinical faculty association. We maintain close liaison. The clinical faculty association began negotiations over this conflict, as we perceive it, before it was aware that OCUFA had any reason to be involved. Since that time OCUFA, the clinical faculty association and the McMaster University Faculty Association have been talking to one another and working towards an agreement, which the proposed amendment would support.

The president of the McMaster University Faculty Association estimates that 120 or more physicians in the medical centre have funding which is not related to fees as clinicians. Mostly, their salaries come from the university or research grants.

Academic working conditions at McMaster are negotiated by the faculty association. We are currently discussing a grievance procedure and a revised promotion and tender document. There are categories in that which would apply primarily to members of the medical faculty.

There have always been serious inequities in the medical school. Because of the way it is set up, people who are employed by the university often work side by side with people who are employed in the medical centre. Research there is not always strictly divided. This agreement, as I

see it, threatens to extend those inequities into the range of the faculty because in both the teaching area and the research area, physicians work side by side with engineers, physicists, biologists and psychologists. In fact, we have people working together who would be covered by separate agreements, and particularly agreements which would cover their working conditions.

With respect to the relationships within university faculties, it is only fair to have all the people doing the same work and have conditions regarding their status in the university defined with a single agreement.

Mr Dawes: My name is Michael Dawes. I am here representing the faculty association of the University of Western Ontario. Our association was formed in 1955 and has grown since then, both in numbers and in the scope of its duties and responsibilities, and is currently recognized officially by the board of governors as a negotiating agent for the faculty on economic working conditions, including salaries, pensions and other benefits. The list has been extended since the statement you have in our brief to include much more general concerns as well.

I would like to stress that our association is not a union. We are not certified. Membership is voluntary. Our membership is currently approximately 850. It is difficult for us to get exact numbers of those members who will be affected by Bill 135 in its current form. Our best estimate, by going through a list of our members and making the decision one way or another, is 124.

Our association is deeply resentful of the way this agreement has been foisted upon us without consultation. To us, it removes a long-established right of negotiation on behalf of many of our members. I wish to speak to some of the statements that have been made by representatives of the Ontario Medical Association.

The first is that physicians are "fundamentally different from the typical university academic." This has certainly not been true in history. I would like to remind you that probably the first university in the modern western world was founded in Italy and was a medical school. The association between medical schools and universities has continued since that time.

At Western we have many professional schools: medicine, business, law, engineering, dentistry, nursing and so on. They form an integral part of the university. There is no clear dividing line between faculty. All of these professional groups are valuable for their teaching partly because of their practice.

Second, we have a statement that "the overwhelming majority of their income"—that is, people in this group—"is generated through the fee-for-service system." We are unable to verify this statement. We do not have access to individual incomes of our faculty members and we certainly do not have access to their OHIP billing records.

We contend that it is all over the place, that there is a real spectrum. Some of our members will have a large proportion of their income derived from OHIP billing and some will have a very small proportion. We suggest that it would be very difficult to verify that. So the statement from the OMA appears to be a matter of opinion.

1600

Third, I would like to look at the claim that "there has been virtually no community of interest between these physicians and other faculty." It just does not seem likely. There are 124 of these individuals who have voluntarily joined our organization. It is hard to explain why they would do that.

As I said in the brief, I do not want to rebut the letter line by line, but I would like to emphasize that we consider many of the statements that have been made in discussions so far to be merely matters of opinion and not backed up by any particular evidence.

I reinforce what Marion Perrin has said: We have no quarrel with the OMA's right to negotiate remuneration for clinical services or other issues which are properly dealt with between the OMA and the government. Some division of the rights and responsibilities is clearly appropriate. We do not see it so far. There are the two areas that Marion has outlined, jurisdiction and membership, which will be difficult to unravel. There are a lot of arrangements and careful negotiations to be done if we are to arrive at a satisfactory conclusion.

We are pleased to hear that the OMA looks forward to working co-operatively with faculty associations and OCUFA in the future, but I should point out that so far our local association has received no contact from the OMA looking for such negotiations.

The Chair: Thank you very much. Further presentations?

Ms Hudgins: Could I have just a few minutes of your time?

The Chair: I have a couple of members who would like to ask questions. You have until approximately until 10 after, so we ask that you leave a few minutes.

Ms Hudgins: I appear here on behalf of the president and the executive director of the University of Toronto Faculty Association. They have asked me to express two concerns. We had hoped that in further discussions with the OMA it would have been unnecessary to come here and express these concerns, but unfortunately we are still in a situation where we have to make them known.

We have two concerns. The first is with respect to those of our licensed MDs who are doing basic health research. They do not see patients. They do not do anything along that line, but suddenly, because of the breadth of subsection 1(1) they are going to be swept into the OMA representation. Our second concern is with those clinicians who do fee-for-service work but who have concerns with respect to tenure and promotion, ultimately academic concerns which our faculty association, if there have been difficulties, has dealt with in the past.

To date, those two areas have not been addressed by the OMA. We have no objection to the OMA continuing to negotiate for fee for service or whatever alternative payment plan may in fact be agreed to with the government, but these other two areas cause us great concern.

The Chair: Thank you very much for your presentation. We have probably enough time for each caucus to have three minutes in total.

Mr J. Wilson: Thank you very much for appearing before the committee today. One of the reasons, of course, we had asked that there be some hearings on Bill 135 was expressly because OCUFA had indicated some concerns with the legislation. We in the Ontario PC caucus are sympathetic to your plight and will be introducing an amendment tomorrow during the clause-by-clause which is almost, except for a couple of legal words, exactly what you are asking for. We will be looking for all-party support on that.

I do need to know a couple of things. One is with regard to clinicians. If the university did not have an agreement with clinicians like the one you have worked with, which you have given us in the brief from McMaster, would that mean the MDs would be paying two fees? Would they be paying an OMA fee and a faculty association fee?

Ms Perrin: One of the reasons the clinicians are interested in this agreement at McMaster is just that; they do not want to have to end up paying two fees. As we see it, there would be a rebate from the OMA fee to the faculty association fee, which is probably about one quarter or less of the OMA fees. That is exactly what is being worked on between the McMaster faculty association and the clinical association at Mac.

Mr J. Wilson: But without an amendment to the act allowing you to do that, it would be clear they would have to pay the two fees.

Ms Perrin: Yes, that is right. They would have to pay the full fee to the OMA, but the fee at McMaster is voluntary. That is why there is a potential loss of membership. Where physicians will have to pay two fees is at Ottawa.

Mr J. Wilson: I understand the fee is not really the issue; it is the other rights.

Ms Perrin: No, it is a small part of the issue.

Mr J. Wilson: You mentioned there are approximately 124 clinicians affected at Western. Do you have any idea what the total number would be at the five medical schools?

Ms Perrin: We are not sure. It comes from the federal level, I understand.

Mr J. Wilson: It is probably not accurate then.

Ms Perrin: There are approximately 6,500 doctors who are associated with universities. What "associated" means is a big question. It could mean they are just associated with them but do not do anything for them. According to these federal stats, there are 2,500 physicians who work full-time in universities, but again, I do not know what it means.

The Chair: Just for clarification, is that full-time in Ontario or across Canada?

Ms Perrin: As I understand it, and I received these from Dr LeBlanc, it is in Ontario.

Mrs Sullivan: Like the Progressive Conservative caucus, our caucus is very interested in what you have to say and our support of the issues you raise. I find it passing strange that you were not consulted in relation to the decisions that were made in the OMA agreement with the

Ministry of Health and did not participate in the vote. Surely that is a significant part of the collective bargaining process.

I wondered why you have not included in your recommendation for the amendment to Bill 135 additional detail about the nature of a dispute resolution process in the course of trying to come to terms with who will represent whom. It seems to me that even with the amendment you have put forward, there still would be required a fee-splitting or fees being paid to both associations. In the case of Ottawa, clearly that would not solve that problem, but as well, when there is disagreement, when the jurisdictional and membership issues cannot be solved, why would you not want to have in statutory form a dispute settlement mechanism?

Ms Perrin: I had not suggested the dispute resolution mechanism until late last weekend, speaking with the OMA on this issue. I felt it was getting late in the process and the bill was coming up and these hearings were coming up. The amendment before you was drafted before I even thought of that. By the way, when I suggested that to the OMA last week, that was the only new issue introduced in our discussions since the summertime.

Mrs Sullivan: We may want to explore that further. If I have half a second, do you believe that in its current state and from its past history of bargaining, the OMA is currently qualified or experienced enough to bargain in relation to the unique situation of physicians on university campuses?

Mr Dawes: We have seen no evidence of that.

Mr Owens: Like Mrs Sullivan, I too found it passing strange that you feel you were not consulted on this legislation. My understanding is that this whole process went through fairly extensive consultations. I am not sure how you were missed or if it was intentional, but are you saying you were not consulted in any way, shape or form on this issue?

1610

Ms Perrin: Absolutely no one at OCUFA and absolutely no one from any faculty association was contacted. The first time we knew about this was in early June 1991, when we saw a summary of what the framework agreement set out with respect to universities. The interesting thing about it all is that the people who negotiated on behalf of the OMA were well aware that there were faculty association bargaining units out there, but in the terribly long process it took to get this agreement, absolutely no one thought to consult with us at all.

Mr Owens: We will certainly ask the OMA the same question. My next question is with respect to the singular bargaining units. The move these days in the health care field is towards single representation rather than having, as one of your presenters indicated, people all over the map with respect to workers in health care institutions. Coming from a health care institution just down the street, I have an understanding of that process. Why is one group taking care of the labour relations aspect with respect to wages and salaries, as I understand the OMA has done in the past,

and leaving folks such as yourselves to address issues around tenure and academic issues problematic for you?

Ms Perrin: In the past the OMA has dealt with the clinical fee-for-service item and that is all. Clinicians who have needed help on their academic issues have come to the faculty associations and it is because, in that area, they have a community of interest with the rest of the people who happen to teach and do research in the university sector.

It is a very complicated area. I have worked for professors for two and a half years now and I would not pretend to be able to tell you everything about it, but the process within the university structure has been so complicated that it requires the expertise that is there and the OMA does not have that expertise. The academic area is probably more important in many ways than the salary issue.

This agreement crosses boundaries. It comes into trying to negotiate now for health researchers who have been and are clearly our members. We have negotiated academic issues for all faculty, or those policies which have been negotiated affect the clinicians, for example, as I stated, the promotion aspect or the promotion and tenure policies. That is because the expertise rests with the faculty association in all those areas and not the OMA.

The Chair: Thank you for appearing before the committee today. We appreciate your very thoughtful presentation. I am sure, if any of the committee members have any additional information they require, they can contact you. Similarly, if there is additional information you think will be helpful, since the committee will likely be making its deliberations tomorrow, I suggest you be aware of that time line so that you can, following today's hearings, submit to us tomorrow in writing anything further you would like to say to the committee.

SUDBURY AND DISTRICT MEDICAL SOCIETY

The Chair: The next presenters are the Sudbury and District Medical Society, Jack Hollingsworth and John Malloy. Please come forward and introduce yourselves to the committee members. We have all received your written presentation. You have half an hour and we would ask if you would leave a few minutes at the end in case any members of the committee have a question. Would you begin your presentation now, please. Just speak into the microphone. Hansard will pick it up.

Dr Hollingsworth: My name is Dr Jack Hollingsworth and I am here representing the views of the Sudbury and District Medical Society.

Dr Kosar: John Malloy could not make it. My name is Dr Stephen Eugene Kosar and I am also with the Sudbury and District Medical Society.

Dr Hollingsworth: Ladies and gentlemen, it is indeed an honour to make this presentation to this esteemed body of politicians today. I stand before you representing the views of the physicians from northern Ontario who are members of the Sudbury and District Medical Society. I will direct my comments to Bill 135, which deals specifically with Randing of all doctors in Ontario. However, because this was presented to the members of the Ontario

Medical Association as a package deal, including the remuneration negotiations and the threshold package, this indeed must come into the discussion.

I will endeavour in this brief presentation to prove beyond reasonable doubt that, first of all, the medical doctors were not given the appropriate information on which to make the decision to vote for Randed. The OMA set out to coerce the doctors to vote on this issue with totally inadequate information and of course also linked it to the emotive issue of remuneration. In addition, I will attempt to prove to you that this package deal in reality translates into rationing of health care.

As my information package will clearly show you, we already have rationing of health care in northern Ontario, dealing with patient-to-doctor ratios three to 12 times those of southern Ontario. Let me emphasize—and I diverge from my presentation for a moment—that those figures are three years old. They are 1988 figures derived from the manpower review and they misrepresent things.

For example, in my own subspecialty, gastroenterology, we have lost one gastroenterologist in northern Ontario. The figures are one gastroenterologist for 152,000 patients, whereas if you compare us to southwestern Ontario, it is one for 73,000, approximately. In fact, we know there are more than 18 gastroenterologists in southwestern Ontario now. Even given those figures, which are not in our favour, we still have huge discrepancies; so we already have rationing of doctors' services in northern Ontario. Let me remind you that for every dollar spent on gastroenterology in northern Ontario, there are two dollars spent in southwestern Ontario, given your own figures, which are indeed out of date and inaccurate at the moment. We can say the same about internal medicine—about twice the rate.

Let me turn my attention now to the Ontario Medical Association itself. Although this association is in theory a democratic body, because of the time lag it takes to become a member of the executive and inner cabinet of the OMA board, this body functions similarly to a politburo. Many of the agendas and decisions are made at the level of this inner board or cabinet and distributed downwards to council in the form of reports.

It is extremely difficult for an ordinary member of the Ontario Medical Association to influence events at this level. I can affirm that. I was present at Maple Leaf Gardens myself. It is very difficult to influence matters at this level. I know the Ontario Medical Association is in the nice position of presenting after me and can comment without my chance to rebut them. I am sure Dr Wyman or whoever is presenting will comment on this, but I can assure you it is extremely difficult to influence the Ontario Medical Association.

In addition, the Ontario Medical Association is a multi-million-dollar-a-year business and funds are provided to specific members of the OMA to sit on committees. Of course, this entails attractive trips to the metropolis of Toronto on a monthly basis for some of these people. The periods differ for different committees.

Let me also point out that the Ontario Medical Association is subject to laws under the Corporations Act and is not allowed to elect its president directly from the floor, as

most unions can; unions are bound by division-of-powers legislation, I understand. This means the president does not stand on a platform and become directly elected but rises through the ranks of the inner cabinet and the board.

In addition, the Ontario Medical Association seriously differs from a normal union in that it is not just there to provide for the welfare of its members, but also describes in its mandate other issues, such as looking after the public interest. Although they describe looking after the public interest, one wonders how much of the public interest of the patients in northern Ontario they have at heart, given that we already have rationing on a two-to-one basis, at least in northern Ontario. This of course will result in draconian cutbacks in health care in northern Ontario.

In addition, members who are Randed will have their fees sent to the Canadian Medical Association to support that organization and also many journals, such as the Ontario Medical Review, the Canadian Medical Association Journal and Humane Medicine. These are distributed to doctors on a regular basis, despite the fact that they may not wish to receive them. These are not small union pamphlets distributed to members to update them on issues but indeed serious medical journals which are largely funded from membership dues.

At the council level, a motion was brought up and passed that the Ontario Medical Association would look at ways of collecting dues from non-members. This simple motion has been exceeded by far in this Randed agreement reached with the government.

Let me direct your attention to the information package and the copy of the proxy votes sent out by the Ontario Medical Association. These votes have only one column you can sign, giving the Ontario Medical Association the power to decide for you what it will do. No information was sent to the members as to how to register a negative vote. The doctors from Sudbury eventually found out, two days before the meeting in Maple Leaf Gardens, how we could bring proxies down. This is against all democratic procedures and in itself constitutes a failure of the medical association to seek the opinion of its members on this matter. One clearly gets the impression that the inner cabinet had made the decision and they achieved the high level of proxy votes by their network of committee and previous committee members distributed throughout the doctors, who are indeed the eyes and ears of the association.

The bargaining unit for negotiating fees also has quite a poor record of representing the needs of doctors in different areas. Although this current agreement may be acceptable to the bulk of the membership, most of whom are from the Toronto and Golden Horseshoe area, this is not acceptable to doctors in rural or underserved areas.

1620

I direct your attention to the information package and the newspaper clippings and photocopies I have enclosed for your information. Ladies and gentlemen, clearly there is a public outcry in the Sudbury district and northern Ontario concerning the proposed changes to the delivery of health care that this package agreement will entail. I draw your attention to Northern Life, November 27, page 5. Six people on the street were stopped and asked, "Are

you concerned about medical specialists leaving Sudbury because of the \$400,000 cap on OHIP payments?" I ask you to read some of the comments these people, who were chosen at random by this newspaper, have made.

The Sudbury Star, Thursday, November 28: "North Facing 'Second Class' Health Care." A letter to the Sudbury Star, Thursday, November 28: "We Must Find Ways to Keep Skilled Professionals." The Sudbury Star, Tuesday, November 26: "Union Urges Rae to Deal with Billings Cap Issue." Clearly, there is a public outcry in the Sudbury district.

This agreement translates into rationing of health care services, and for "joint management committee," please read "rationing of health care services." This is not acceptable to the public or to the physicians in northern Ontario. This bargaining unit, in accepting this agreement without consulting the membership appropriately in northern Ontario, has not represented our needs.

I enclose a copy of the relevant pages of the memorandum of agreement between the Ontario Medical Association and the government. The full memorandum was not circulated to us. I have one copy here for records. This was not circulated to the doctors before voting on the agreement. Fortunately for Sudbury, some forward-thinking representatives got us copies of this agreement, and indeed predictably we voted against the agreement.

I now draw your attention in particular to page 4 of the interim agreement on economic arrangements, section 10, subsections (a) and (b), which is in your package. This clearly states that threshold payment adjustments do not apply to physicians working in underserved areas, but there is an important clause there, by arrangement with the Minister of Health or where the minister determines that a particular physician in a particular geographic or specialty area may be exempted.

I now draw your attention to the next page, the Ontario Medical Association summary of the agreement, which was a press release. This indeed is quite a rosy view of this statement. This clearly states that the threshold payment adjustments do not apply to physicians working in underserved areas. Surely Sudbury is indeed an underserved area, given the enclosed statistics I present to you concerning the doctor-to-patient ratios. The fact that this is a media fact sheet given by the OMA to the press—and the government must have been aware that this was a misrepresentation—would suggest that the government might have intervened on behalf of the doctors and their patients and constituents who are misrepresented by this Ontario Medical Association press release.

Finally, with regard to the Ontario Medical Association, the negotiations were performed prior to any consultation with the grass-roots membership and indeed were presented as a fait accompli and a package deal. The Rand agreement is a sweetheart deal for the Ontario Medical Association. The package deal is a sweetheart deal for the government, a very poor deal for the doctors and an extremely poor deal for the public, particularly those in northern Ontario.

At this point I would like to move on and direct your attention to the fact that the Sudbury and District Medical

Society has been a direct negotiating body with the government and is meeting with Mr McMillan from the OHIP program, has met with Mr Floyd Laughren and Miss Shelley Martel, and indeed hopes to meet with Ms Lankin and Premier Bob Rae. I therefore submit to you that the bargaining unit of the OMA has not represented us as members and we should be allowed to form our own separate union if we so wish.

In evaluating these newspaper articles, I ask you to pay attention to the opinion of the man on the street and the public outcry that is occurring, the fact that the OMA has fallen down in its mandate as protector of the public interest. I also have submitted for your information a videotape of our most recent regional council meeting which clearly illustrates some of the problems associated with this package deal, particularly for the constituents in northern Ontario. I strongly urge you to view this videotape. It is extremely important for you to understand what the issues are in northern Ontario, and it is almost a manual of how the legislation and the government and the Ontario Medical Association should have gone about bringing changes in health care, rather than the way they have been brought upon us.

I would now like to emphasize the point that this current legislation, in total, represents rationing of medical services. We are discussing Bill C-135, which is part of a package deal presented by the Ontario Medical Association to its doctors, and I therefore feel this is relevant to my arguments.

In Sudbury, we will have virtually no obstetrical services in the beginning of the new year. Our cardiac surgeons and cardiologists will also be out of commission. We now have one neurologist. We may well have no neurologists in the new year, and other subspecialists who have co-operated with the neurologists in covering neurology no longer feel they can be part of this because their own subspecialty is indeed threatened by this legislation.

There will be a domino effect from this legislation in that each subspecialty is interdependent on the other subspecialty. For example, if a patient is admitted for cataract surgery, he may have pre-existing heart and lung problems and may require thallium stress testing or pulmonary function testing or evaluation by a cardiologist, respirologist, gastroenterologist, etc.

Once these services begin to disappear, it will be impossible to proceed with routine operations such as cataract surgery, hip surgery, etc. Also, I point out to you that it has been extremely difficult to bring Sudbury medical services to the level they are now at. I have personally striven over the last four years to recruit internists and medical specialists to the north, with much difficulty.

We have recently lost a general internist and respirologist to a southern teaching hospital. He has indicated problems with the type of lifestyle associated with living in such an underserved area, being perpetually on call for extremely ill patients, dealing with financial cutbacks by the hospitals and dealing with geographic distances involved and logistical problems in transporting patients from outlying areas to Sudbury. These were all major factors in his decision to leave, and he has been followed by other doctors. We have

lost a psychiatrist and an ophthalmic surgeon recently also. Many of the specialists in northern Ontario feel the same way as this doctor did, and we feel a special case must be made for northern Ontario in this situation.

Also, it is clearly obvious that the current plan to fly in doctors from outside northern Ontario to service needs will be ineffective in saving money, and patients travelling south will cost more than the estimated \$25 million that was spent last year on travel grants. In addition, fly-in doctors rarely provide long-term follow-up to patients, or indeed emergency care, but tend to hive off elective work and bring their medical income back to their home towns, which will be in southern Ontario, to spend. This will of course weaken the northern Ontario economy.

I am sure you all know that the plan—and the OMA has been party to this—is to allow the specialists in the southern Ontario region to have a separate billing number and then to fly north; when they are not providing services here, to provide them in northern Ontario on basically a flying-doctor regime. That videotape I have left for your reference clearly illustrates we do not want that and we do not think it is appropriate.

Finally, I would like to propose an amendment to be considered by the members of this subcommittee concerning Bill C-135. The amendment reads:

“Those doctors who belong to another medical association which collects dues may be exempted from membership from the Ontario Medical Association if they so wish.”

The membership in the Sudbury area feels they have not been represented by the Ontario Medical Association. Indeed, I have heard the name coined, “the odious medical association.” They have been tricked by delayed distribution of information, by misinformation to the press, which is clearly documented in your handouts, and by packaging the Rand formula with a financial remuneration package for the doctors. We feel it is totally unacceptable to have further rationing of health care in northern Ontario and can, under no circumstances, support this.

We wish to point out to you that the Ontario Medical Association is by no means a union. The president is not elected. The delegation process is extremely indirect, going via medical society, branch society, delegates to council, and finally to the Board, which then elects a representative. What this creates is a central bureaucracy which is self-fulfilling and functions in the way we have seen the OMA function over the last several years.

We did not vote directly on the Rand agreement. There was no yes or no vote possible in the proxies forwarded by the Ontario Medical Association. The Ontario Medical Association sympathizers were used to coerce other members to provide proxy votes in a positive fashion to the Rand formula.

The Ontario Medical Association also has a mandate to represent the public, which no other union has taken upon itself when looking for Randing, and indeed, many of the Randing fees go to support other factors besides the bargaining unit, publications of journals and running committees.

We wish to reinforce the statement, “No taxation without representation,” particularly concerning the bargaining

unit. We wish to refer you to division of powers under which union rights are protected and unions are allowed to elect their president, who runs on a platform in a much more democratic fashion than the Ontario Medical Association tends to function.

Ladies and gentlemen, if you must Rand me, I ask that you Rand me to Local 598, Canadian Union of Mine, Mill and Smelter Workers, and I will take my chances with Mr Rick Briggs, in whom I have more faith than the current leadership of the Ontario Medical Association.

1630

Dr Kosar: I will also address a few points. I am an ophthalmologist with subspecialty fellowship training in retinal diseases. I am the only fellowship-trained retinal specialist in northern Ontario.

I think also that Bill 135 is part and parcel of the entire OMA agreement and we must address the whole agreement. We feel that the OMA did not consider the impact of this agreement on our patients in the underserved north. I would like to illustrate the rationing of services already occurring in my practice, and I am sure this is reflected in other people's practices.

I occasionally am involved, a couple of weeks a year, with the Canadian National Institute for the Blind which provides services in its travelling-eye van to underserved areas in northern Ontario. They have applied for exemption from the billing cap for physicians who volunteer their time and take time away from their practices to provide services to people who otherwise would not be able to see an ophthalmologist. To date, they have not received news of any exemption, and if they do not have an exemption from the billing cap, this much-needed service will not be provided by this volunteer organization.

Last week I had a 24-year-old girl show up at my office with sudden onset of loss of vision. I felt this was optic neuritis; however, I had to arrange for an urgent CAT scan. Fortunately, due to the foresight of doctors in Sudbury in the past 10 years, we do have a CAT scan and this was readily available. Once this procedure was performed on Friday afternoon, I was advised to get a neurologic consultation. There was no neurologist to be found. This, my friends, is something that illustrates the already occurring rationing of services in northern Ontario. Had this young lady been in Toronto or somewhere in southern Ontario, she would have had a second ophthalmic consultation by now, probably a neuroophthalmologic consultation as well as a neurologic consultation, and probably a magnetic resonance scan.

This is not an isolated example. There are many such examples in many specialties of rationing of services that are not available in northern Ontario. This will only get worse if the current situation continues. I would like to ask this committee to reconsider Bill 135 and to consider its impact on the patients of northern Ontario. Thank you for your time.

The Chair: Thank you very much for your presentation. I have some questions from committee members and I believe we will have enough time for about four or five minutes from each caucus.

Mr Owens: My first question is to the parliamentary assistant with respect to the statement that was made about physicians given a special billing number who fly north to treat patients so that, in fact, it is an end run around the cap. Is that true?

Mr Wessenger: I will ask Dr Le Blanc to answer that question.

Dr Le Blanc: The provision for specialists coming to the north into clinics is by arrangement usually with the physicians within the community. Wherever those physicians come from—many of them come from Sudbury and Thunder Bay, some may come from southern Ontario—they are exempt because there is a separate billing number. Many of them do not bother to bill fees for service. They go on sessional fees, in which case, from wherever they are, that does not affect them. The sessionals will not affect fee-for-service income.

Mr Owens: My question is to the presenters. In terms of your presentation, I heard two entirely different messages. First, you do not think your union represents you, and second, the north is underserved with respect to health care practitioners. I do not think there is anybody in this room who would argue that the north is not underserved in terms of medical care and we are certainly working on ways to ameliorate that concern.

The question about your union, however, is a little different. Are there not avenues for people in your section or like-minded individuals across the province to participate? In my own union, if we did not like what the executive was doing, we challenged those individuals and either removed them or had them take a more progressive line. Is that not an avenue within your organization? Have you not done that?

Dr Hollingsworth: Unfortunately, the structure of the OMA is extremely complex. There are many roads to leadership of the OMA, which takes an average time of eight to 13 or 15 years. On the central board or inner cabinet there are 23 board members. The board elects the executive. The general secretary is elected by the board, not by the membership, so what I am asking for is a little bit of perestroika in the OMA. Now, I am going to the wrong people—

Mr Owens: I find this extremely odd, to sit here having doctors complain that their union does not work.

The Chair: Mr Owens, you have used your allotted time. Dr Hollingsworth, you may answer.

Dr Hollingsworth: The reason we are presenting this is to use this as a platform to make you aware that there are very basic problems in health care that the Ontario Medical Association has not faced up to. Indeed, in the northern Ontario situation, this attitude of flying people in is not going to work, because they are not going to be living there and taking calls at night. I take calls every sixth night. If I moved to Toronto or Guelph, I would probably take calls much less frequently, for much less sick patients. We do not tend to fly people out of Sudbury; we keep our patients there. There has been much less transfer of patients down south over the last 10 years.

We have built up a really good tertiary-level health care service with the help of local politicians and the local community. We were told we could not raise money for a cancer clinic, that we could never raise \$3 million. We raised \$9.3 million. We were told we would not be able to get a CAT scanner, and we bought it ourselves. We have been very active in improving health care service in northern Ontario, and the doctors and the politicians and the public have all got together and done this.

What we are saying to you is, let us have our own association if we wish, if our medical society takes a vote on this. We would be willing to give them a democratic chance, unlike the OMA's attitude, which was to come with 8,500 proxies in its back pocket that were basically coerced out of the membership by what we would call OMA hacks. We will give our membership a chance to vote, and we will ask them: "Do you want to be in the OMA or do you want to be in the medical society? Do you want us to bargain for you? Do you want us to bargain for your patients? Do you want us to make your case?"

I think you will agree, ladies and gentlemen, that you have heard more about northern health care today than you have heard for a long, long time from the Ontario Medical Association.

The Chair: Mrs Sullivan, you have the floor.

Mrs Sullivan: I am interested in a particular point you raised in relation to patient service in the north and the part of the agreement that, in summary, left out some important information, which was that the threshold adjustments do not apply unless there is concurrence and agreement and participation of the minister in making that decision. That is clearly one of the things that is problematic here, in that northern doctors, it appears, cannot have the cap removed to service patients in the area, whereas southern doctors can have the cap removed to service patients in the north. While that may not be specifically applicable to Bill 135, it is certainly applicable to a portion of the agreement in which there is a problem.

I have been quite interested in comparing the population per physician, north versus south. I wonder if you are seeing, as a result of that cap, services being eliminated which might include even outreach services that you provide in communities outside Sudbury, for example, or a large location, but where you are actually taking your services on the road, which a southern doctor would not do.

Dr Hollingsworth: We provide services to all the outlying areas. First of all, any patient who becomes very ill during the night or on the weekend is transferred to Sudbury. We also provide outreach clinics all around the area, Manitoulin Island, Elliot Lake, Kapuskasing. We understand the ministry has looked at this problem and is going to give us separate billing numbers, but we have not had the final word on that.

The problem is that even with flying people in, it is the emergency services that are the most critical and these are the ones that are going to suffer. If people leave, even if they leave for three months because they have reached their cap, they are no longer available to take calls. We feel this should have been exempted perhaps from the call

system. What we are asking for is an exemption for the patients of northern Ontario.

1640

Just look at your numbers, your statistics. Even though we feel your figures are wrong and that we could perhaps adjust them for you by 50% or 60%, we will live with your figures. Please exempt the patients. Take the threshold off northern Ontario patients and let them have the same access to health care dollars as southern Ontario patients. We ask you this as representatives of the Sudbury and District Medical Society, and we are appalled that the Ontario Medical Association has not asked you this.

Mr J. Wilson: Thank you for your very informative presentation. I do have a question for the parliamentary assistant, stemming out of the terminology used by Mr Owens. On three occasions, Mr Owens, you referred to the OMA as the doctors' union. It is fairly clear—to me, anyway—in reading the agreement that the OMA is going to be the doctors' trade union, but I do have a question for the parliamentary assistant. Is that government policy now?

The Chair: You can ask that of the parliamentary assistant, but not of Mr Owens.

Mr J. Wilson: They are all the same. They are all in collusion, so I will ask the parliamentary assistant. Is that government policy, that the OMA is now a trade union? I would like that cleared up for the record.

Mr Wessinger: The OMA is the bargaining agent for the doctors. Whatever you want to call that, that is basically what it is. While I have the floor, I might just say that there seems to be some lack of clarification with respect to the whole question of physicians working in underserved areas. Any physician who is working under an underserved area program is exempt from the threshold. I think that should be clear, and I think maybe the doctors here are working under an underserved area program.

Mr J. Wilson: That is different, and I would like the presenters to clarify that. That is part of the problem here.

Dr Kosar: Part of the package, part of the agreement, was clause 10(a)(i), which talks about "physicians working in underserved areas by arrangement with the Ministry of Health under the Ministry of Health underserved area program."

I myself am under the underserved area program because I have been up in Sudbury for only one year now. However, I have a letter here from the Minister of Health, a "Dear Applicant" letter. I had applied for an exemption, and it says that I am not exempt from the cap.

Obviously there has been a mixup in communication between the Minister of Health and OHIP, or the billing agency. I know others who have been in the same situation, so there obviously has been a lack of communication. I am not sure where that fault lies, whether it is with the Minister of Health or with the OMA, communicating to the Minister of Health who these doctors are who are participating in the program, so right now I am kind of confused.

Mr J. Wilson: In the case of specialists who do reach the cap and will be no longer practising, can you give an

example of the cost to the government in terms of having to transport patients and doctors and families to the south?

Dr Kosar: I can give you an example based on my own practice, and again, this is probably reflected in other specialists' practices. I see at least 20 people a week who, before I came to Sudbury, would have had to be transferred to Toronto or another teaching centre for specialized eye care.

If you just look at the cost of the travel grant from Sudbury to Toronto, I believe it is about \$150 per patient. You also have to realize that these patients often travel to other centres for repeat visits. But even if you only assume one visit per patient, at 20 patients a week, that is \$3,000 a week, which translates to about \$150,000 a year. I figure I am saving the government at least that much money by being in Sudbury. Transporting physicians from southern Ontario to northern Ontario as itinerant physicians will not work. It is still going to cost the government money to send them up. We need physicians to live, work and play in northern Ontario.

The Chair: Thank you very much. I have a request from Mr Hope. If the committee will permit, he would like to ask one very short question. Time has expired. What is the wish of the committee? Agreed? Mr Hope.

Mr Hope: My question stems from the \$400,000, when you said you would start transferring. You mean you would have a person referred outside your community instead of treating him, even though you have met your cap? You have met your cap and you are telling me you will not see another person to treat?

Dr Hollingsworth: Let me clarify that. I think that is a very good point. You are obviously focusing on finances and numbers and money here, and that is not what we came here to focus on. But if you want to focus on that, this \$400,000, we do not receive this as a salary. We lose over half of it in terms of overhead, okay? Do you understand that?

We have an overhead. I have two nurses, I have two secretaries, I have a dietitian. If you come to see me, you need services. You need procedures done, you need to get dietary advice, you need to see my nurse, and that costs me money. If I am going to be paid one third of what I should get, and it is costing me 50% of what I should get, I am losing 20 cents every time I see somebody like you. I can only do that for so long before my bank manager calls in his notes, and I think you have to realize that I would become insolvent. I would like to do it, but I physically cannot do it.

Could I make one other comment with respect to the comment from the parliamentary assistant about the OMA becoming the doctors' union? If you are saying to us that the OMA is going to become our union, can you maybe suggest to it that we be allowed to elect our president or our general secretary? I personally would be quite willing to run for that job.

I have gone to the OMA this morning and put my name down for the job of general secretary. I am sure I will not be given the job, given that my views are so different from those of the current leadership of the OMA. But I think

maybe they do need someone like me for a year or two. I am willing to give it two years, and I am willing to be kicked out after two years and then elect someone who is better than me if the membership so feels.

I asked the OMA's currently sitting temporary general secretary how I could go about getting elected. He said, "You could talk to Dr Wyman or Dr Thoburn." Well, I said, I am so different from those guys that the last time I talked to them they did not have anything nice to say to me. He said, "Yes, but it's tough, because they would have to change all the bylaws, and we cannot change the bylaws." I said, "Well, gee, isn't it sad, because I would like to go around and poll the membership and say, 'Look, I can do something for you guys. I can do a better job than these guys are doing for you, and I can ask your opinion a lot more.' But you are saying I cannot be elected." He said, "Let me think about it." So I am waiting for his response.

The Chair: I think all members of the committee realize that your comments were facetious. Some would suggest they are not. In that case, this is your opportunity to come forward to discuss Bill 135. It really is not an opportunity for a job interview. If you wish, we could forward the Hansard of your comments to the Ontario Medical Association. In all seriousness we do appreciate your coming before the committee today and sharing your concerns with us.

The committee will be dealing with this legislation tomorrow. You mentioned before that you would not have an opportunity to rebut, and that is quite correct as far as appearing before the committee again is concerned. But if there is anything you wish to communicate to the committee, you may do so; you have all morning tomorrow. We will be meeting again at 3:30 p.m., so anything that is said today that you would like an opportunity to rebut, you can submit in writing tomorrow. Thank you for appearing today.

Dr Hollingsworth: Thank you very much, Madam Chair. I have not given up my daytime job yet.

The Chair: Do not lose your sense of humour either.

I would like to call next the Ontario Medical Association, my old friends Michael Wyman and David Peachey. Please come forward and introduce yourselves to the committee. You have a half-hour for your presentation, and we would ask you to leave a few minutes at the end of your presentation for questions from committee members. Welcome.

Dr Wyman: Thank you, Madam Chairman. I am Dr Michael Wyman, a family physician in North York and still a member of the executive of the OMA. I am a member of the board and I was the chief negotiator of the agreement from which Bill 135 arises.

I have with me today Dr David Peachey, director of professional affairs at the Ontario Medical Association, and Ms Georgia Henderson, manager of professional affairs.

The purpose of this brief is to respond to the amendments that were proposed by the Ontario Confederation of University Faculty Associations, which are intended to develop an exemption on agreement for physicians affili-

ated with Ontario universities from the application of Bill 135, An Act to provide for the Payment of Physicians' Dues and Other Amounts to the Ontario Medical Association.

The bill as presently proposed provides that all physicians licensed to practise in Ontario, who engage in the practice of medicine or conduct health research in Ontario, are to pay the equivalent of dues to the Ontario Medical Association on the same basis as if they were members.

1650

In considering the proposed amendment, it is critical that the committee be fully aware of the rationale for the payment of the equivalent-of-dues payments to the Ontario Medical Association. Once the underlying rationale is clearly understood, it is the position of the Ontario Medical Association that there can be no principled reason for exempting some physicians from the payment of such amounts on the basis that they may have an appointment to an Ontario university.

As we will discuss further, in all essential respects related to the memorandum of agreement between the government and the Ontario Medical Association, which had been sent to every member of the OMA prior to the agreement, the Ontario Medical Association plays a critical role in representing the interests of physicians who hold a university appointment. As a result, the proposal to exempt these positions from the payment of OMA dues cannot be supported either in logic or in equity.

The physicians who would be subject to this amendment consist of an undetermined number, likely in the range of 3,000 to 5,000, constituting up to 20% of the membership of the OMA. It is necessary to understand that the overwhelming percentage of these physicians do not function in an academic university setting like, for example, a history professor, but rather practise medicine in the public teaching hospitals of the province, where, integrated with their essential patient care services, largely tertiary care, they perform teaching functions.

The remuneration of such physicians consists largely of billings to OHIP, compensation which is negotiated solely between the government and the OMA. There is and can be no role for OCUFA to play in this critical aspect of clinical practice. This alone justifies the requirement that these individuals pay the equivalent of dues to the OMA.

In order to place the proposed amendment in perspective, it is necessary to understand the role which clinicians play in the health care system and the manner in which they provide their services and obtain their remuneration. Contrary to the impression which OCUFA may seek to give, all physicians who are subject to the proposed amendment are licensed physicians who practise medicine in Ontario or conduct health research. While these doctors may have some university affiliation, they are not restricted in their operation or remuneration to a university setting. Thus these physicians teach and practise in the hospital setting, where their teaching responsibilities are inextricably bound up with the practise of medicine.

Such physicians, aside from holding a university appointment, also hold a hospital appointment and generally bill OHIP for the provision of services to the people of the

province of Ontario. They mostly belong to group practices and partnerships, where they carry on medical practices as independent practitioners.

Practically all physicians who have appointments in these hospitals spend a large percentage of their working day performing work governed by the OHIP schedule, and it could be reasonably estimated that 80% to 90% of their income is generated through the fee-for-service schedule which is negotiated by the OMA. While such individuals have a university appointment as well, very little of their income is derived from university sources. Real university funding, or hard moneys, were always small and have been getting much smaller all the time. Even those persons who are engaged solely in research obtain much of their income directly from OHIP amounts, since in many cases academic clinical earnings are subject to an upper ceiling and the earnings over that ceiling are used to provide income to faculty, including researchers.

Further, because the overwhelming percentage of such clinicians hold hospital appointments, their concerns are not restricted to matters dealing with the university but are critically related to all health care matters involving the operation of public hospitals and the health care system itself.

It should be noted that the government has entered into discussions with university faculties of medicine, the OMA and clinical teachers' associations with respect to altering the existing fee-for-service method of payment and establishing alternative payment plans. In a number of departments in some health science centres, agreements have been concluded directly with the government. The OMA and its designate, the clinical teachers' associations, have in most cases performed the critical role representing clinicians in dealing with the government and the deans of medicine on all issues surrounding these alternative payment plans. The faculty associations which belong to OCUFA have not been involved in these issues at any time.

The underlying rationale for Bill 135 is that all physicians in the province of Ontario who benefit from the association's activities should help to defray the costs. Historically, one critical role for the OMA enshrined in statute and recognized in the agreement is the negotiation of the fee-for-service schedule. It is also recognized that the fee-for-service schedule sets the standard for most other forms of physician remuneration.

The bill gives effect to the principle that all who benefit from fee-for-service amounts negotiated by the OMA should be required to pay their fair share of the financial efforts to obtain them. In this respect, as noted above, clinicians who hold hospital and university appointments are no different from any other physicians in the province of Ontario: The overwhelming percentage of their income is derived from billing OHIP for the performance of clinical services, and the fees which they are paid directly result from the amounts negotiated between the OMA and the government.

It would be inequitable to grant exemptions from a requirement to pay an amount equivalent to OMA dues on the basis that some of these clinicians have a small compo-

nent of their total compensation from universities. Indeed, that component of university salary not infrequently is funded by OHIP billings. These moneys, often referred to as soft moneys, originate from fee-for-service billings, are remitted by clinicians to the university and then returned to the physician in the form of salary.

However, it should be noted that the framework agreement between the government and the OMA is not limited to the negotiation of the fee schedule itself. The OMA and the government have agreed to co-operate in the joint management of all physician services to achieve more value for health care spending in Ontario. To this end, they have agreed to establish a joint management committee to improve the management of the system in pursuit of high-quality medical services and related health care services in the province.

The mandate of the JMC includes action seeking to enhance the quality and effectiveness of all medical services; to develop and implement effective utilization management for all physician services; to develop and implement incentives to all physicians to bring about more cost-effective and efficient delivery of health care; to discuss strategies for the implementation of the improvement of the number, mix and distribution of all physicians; to monitor the volume changes in both the fee-for-service and non-fee-for-service systems, and to make recommendations with respect thereto.

In engaging in its endeavours in the JMC, the OMA will be required to provide significant resources, including its staff and the resources of its members. It is only fair that all Ontario physicians be required to assist in defraying the cost incurred by the OMA in the representation of all physicians in the JMC. In this respect, clinicians who hold a university appointment are no less concerned than are other physicians in relation to these issues.

It should be noted also that the OMA negotiates significant benefits for all physicians, whether fee-for-service or non-fee-for-service, including the reimbursement of certain Canadian Medical Protective Association payments. These amounts, which defray liability insurance payments, also are payable to physicians who hold university appointments.

The OMA represents all physicians in the development of social and health policy in the province and represents all physicians in consultations respecting possible legislation. Through the work of the department of health policy and its committees, public policy and public health are impacted in countless areas of clinical endeavours.

In summary, the historical rationale for the Rand formula, that all who benefit from the activities of an organization should contribute to that organization, applies with significant force to these particular physicians because of the OMA's traditional role in representing all physicians in such areas as fee-for-service and benefit negotiations, because of the significant impact that its role on the JMC will have on all physicians in the province, and because of its historic role in the development of public health policy in the province.

In all other provinces where Rand legislation has been enacted for physicians, no exemption is made for physicians who hold university appointments. In Ontario, given

that the OMA carries out the same functions as organizations in other provinces and has now assumed even greater responsibilities through the JMC in matters affecting both fee-for-service and non-fee-for-service physicians, and in furthering the public interest by working towards the establishment of a more effective health care system in the province, there is no rationale for such an exemption.

It is simply wrong for OCUFA to assert that the provisions of Bill 135 result in the raiding of membership. The OMA has always represented clinicians with university appointments in fee-for-service negotiations and has been involved with them recently in discussions regarding alternative payment plans. These physicians have always been an integral part of the OMA organizational structure. For example, the current president of the OMA, Dr Adam Linton, is a full-time clinician at a teaching hospital affiliated with a university. So too is the former president of the OMA and current president of the Canadian Medical Association, Dr Carol Guzman. I am not a full-time but a part-time clinician, holding the appointment of assistant professor in the department of family and community medicine.

1700

The OMA has had a central role in representing all these physicians because their sources of income and professional lives are entirely different from other university faculty. Historically, there has been no community of interest between these physicians and other faculty in these respects. One point should be made very clearly, and there appears to have been some misconception about this in the debates in the House, that to the best of the OMA's knowledge none of the opposition to this bill, on the basis advanced by OCUFA, has come from the clinicians themselves. We stand to be corrected, but we are not aware of any clinician with a university appointment who has come to us and said this bill is unfair because of some impact on a faculty association. Indeed, these clinicians were a large part of the 80% of the voting OMA membership that overwhelmingly approved the new agreement with the government, including the provisions respecting dues deductions last spring, having had a full and profound discussion of the contents of the agreement prior to the presentation at the annual meeting and the general meeting.

It should be noted that the physicians in question are not precluded from joining faculty associations in addition to the OMA, and the faculty associations are not precluded from having a role in certain aspects of university life affecting these physicians. This fact, however, does not in any way justify exempting these doctors from the obligation to pay dues to the OMA, which clearly has and will continue to represent them in a myriad of ways relating to their professional life. Membership in faculty associations will remain, as at present, a voluntary decision by individuals, and the OMA will not interfere with physicians who choose to belong to such associations in addition to the payment of the equivalent of dues to the Ontario Medical Association. Thus the allegation of loss of membership by OCUFA cannot be supported. Moreover, the OMA and clinical teachers' associations wish to work positively and co-operatively with faculty associations in areas of com-

mon interest and concern. It has been our desire all along to develop a co-operative working relationship, and we will continue to approach that. This has been and continues to be clearly expressed to OCUFA. Concerns regarding the legislation in these circumstances constituting a threat or a raid are simply unwarranted.

Finally, the adoption of the proposed OCUFA amendment could seriously jeopardize the ability of the parties, both the government and the OMA, to engage in good faith negotiations in the future. The agreement entered into between the government of Ontario and the Ontario Medical Association and its members provided that the government would support the statute providing for the payment of dues by all practising physicians. In this respect, it stated specifically:

"The government undertakes to introduce and support a statute, to be given first reading before June 30, 1991, and effective as of that date, providing for the payment of dues or their equivalent to the association by all practising physicians in Ontario. The principles of this statute are set out in the appendix A to this agreement."

It would simply not be a measure of good faith, which would facilitate the type of relationship which the government and the OMA clearly envision, to have one party unilaterally alter the agreement reached at the bargaining table. The future stability of the bargaining relationship requires that commitments made at the bargaining table be honoured and implemented.

In light of the foregoing, there is no reason in policy or logic to exempt physicians who hold university appointments from the effect of Bill 135. Indeed, the purpose of Bill 135 can only be served if such physicians are included within its ambit.

In response to some of the comments that were made in the representation by OCUFA and the request that there be a local negotiation of fees and roles, and to continue to develop the relationship between the local faculty associations and the OMA, we absolutely agree. We do not believe that has anything to do with the passage of Bill 135. We contend that this type of negotiation and local agreement would continue beyond the passage of the bill and would enter into an agreement in each of the areas.

I would remind you that prior to the agreement being signed, there were agreements that had been developed between the clinical teachers' associations in each of the five universities that understood fully the content of the agreement.

Mr J. Wilson: Dr Wyman, you talk about agreements with faculty associations. The amendment we are putting forward would really require you to enter into an agreement with faculty associations before the act would apply to the positions currently covered in the university environment. You may want an opportunity to explain in a minute or so exactly why you could not come to an agreement with those faculty, given that you are talking about co-operation.

I am a former governor of the University of Toronto and spent two years, a considerable amount of time as I recall, talking about benefits, salaries and working conditions for medical practitioners in the faculty of medicine. I

have a brother at the University of Western Ontario who is one of those people: I do not understand. I have a great deal of sympathy for OCUFA in terms of those people, including my brother, who work 24 hours a day at the university and have nothing to do with the OMA. He certainly looks at his faculty association as his representative.

Dr Wyman: Currently, 80% of the members of the teaching faculties around the province are members of the OMA. To have Bill 135 apply to the other 20% would not have a significant impact on their ability to continue to function as they do. In fact, we are in the process of negotiating on behalf of a large number of clinical teachers' associations and we reached agreement with the clinical teachers' groups prior to the passage of the bill. There are a large number of clinicians who have university appointments who never heard of OCUFA before this time. I am a clinical teacher and I was not aware of OCUFA or of any direct involvement by the University of Toronto faculty association on my behalf.

Mr J. Wilson: I do not recall any physicians ever showing up at the board of governors' meetings, which means the interest is pretty low there.

Dr Wyman: The OMA continues to function in a large number of areas that continue to impact on the practice of medicine outside of the direct appointment. I think Dr Peachey could enhance that a little bit, as he has been doing much of the negotiations with universities.

Dr Peachey: Perhaps I could clarify one thing the member stated: The arrangement and letters of understanding the OMA has signed for the past two years have been with the clinical teachers' associations and not the faculty association per se. The clinical teachers' associations are growing and strengthening organizations in the province on the basis that the clinical teachers in the five health sciences centres were looking for local organization in terms of representing many of their interests. It was with that in mind that the corporate OMA certainly believed it did not have the basic academic standing and understanding of the complexities of academe, and it is very supportive of the CTAs in that regard.

Mr J. Wilson: On the collection of OMA dues by the government, does the OMA reimburse the government for collection of dues and the administration thereof? It seems very strange to me that the government is in the business of collecting the dues of a trade union which it is terminating. It just blows my mind. I do not think my constituents would necessarily agree with this precedent setting. There is nothing I can do about it, I know, because it is not necessarily part of Bill 135 in that the government will vote as a block against it, but I would be interested to know whether the government is getting any reimbursement for this.

Mr Wessenger: Under this bill the government will be collecting the dues and there will be no charge to the OMA. Just as with any employer who collects dues, there is no charge to the association.

Mr J. Wilson: Is the cost of operating the joint management committee shared by the government? It seems to

me it has a pretty wide mandate and will be doing a lot of work over the next few years.

Mr Wessenger: I understand the Ontario Medical Association members bear their own costs of participating in the joint management committee.

1710

Mr Malkowski: I would like a point of clarification in terms of the membership election process. The members have a direct involvement in electing the executive directors of the OMA. Could you explain that for me, please?

Dr Wyman: There are two streams within the Ontario Medical Association: the staff and an elected representation. The chief executive officer of the OMA is a paid position and is responsible to the executive and the board of the Ontario Medical Association. The Ontario Medical Association has 24 board members elected by region, by population around the province on an annual or biannual basis. These elections are open to all members of the association and the executive of the OMA is elected from the membership of the board.

The president of the OMA is part of the executive and is elected by the board, so there is direct representation through the membership to the board and to the executive. An additional component of the democratic process involves our council, which is a representation by population around the province and is broken down into branch societies basically related to a geographic region usually centred on a hospital. This consists of approximately 200 people elected by local representation so there are two very clear avenues of approach for the general membership of the Ontario Medical Association towards the decision-making process.

Mr Brown: I am interested in your public interest mandate. We have heard from the previous presenters about the lack of positions in certain parts of the province, particularly northern Ontario. I will speak about that since I am a northern member. The distribution in northern Ontario is remarkably less than in the south, but I will not go through the figures right now. I wonder how this agreement is going to help northern physicians or attract people in the various specialties to the north. It is not good at present and I cannot see this helping.

Dr Wyman: I do not believe Bill 135 will have any impact whatever on whether physicians go north or south, since it has to do with mandatory dues. The general agreement between the government and the OMA, in its extended process, really sets up through the joint management committee the opportunity for the OMA and the government to work conjointly towards developing manpower policies and a way of resolving the issues. I think there is a very clear desire by the Ontario Medical Association, both its elected members and staff members and the membership of the organization itself, to provide adequate health services to all people in Ontario in whatever location they happen to live. There is also a current action plan being developed through the OMA and the joint management committee on these very issues.

Mr Brown: I realize this is about the Rand formula, and I have just heard a presentation from members of a

large medical society in this province from northern Ontario that told me they do not think the OMA represents their views. Their view is that this formula exacerbates a shortage of physicians in northern Ontario. Just so you understand, if you figure out the allocation per capita in the regions, this formula means the north will get about \$200 per capita less for each position in northern Ontario. That is what this does. I can understand that the physicians in northern Ontario are pretty unhappy about that. More than that, the patients, the people of northern Ontario, are pretty unhappy about it.

In your public interest mandate, when we have a letter from the minister saying she is not going to extend this, I do not understand when you talk about negotiating. The minister said what she is going to do. She is not going to negotiate—no more extension of the underserved program grants or lift of cap.

Dr Wyman: The OMA has publicly stated that we felt the decision by the minister up to this point was against the intent of the agreement, and that the decision to have no further exemptions applied was an inappropriate process. There have been ongoing discussions, both prior to that time and since that time, to try to extend the exemptions, to try to provide for continuing services to the people of the north. We do not agree that the application of lack of exemptions is an appropriate method of providing services to the people of the north or the south.

Mr Brown: In the jargon of labour relations, we would say now that the Minister of Health is acting in bad faith in terms of this agreement.

Dr Wyman: I would have to say that is not the case. The Minister of Health has acted to the letter of the agreement and has fulfilled the exact wording of the agreement. It was not our intent when we negotiated the process that there would be no exemptions, and we continue to try to work to provide exemptions for services in the north and underserved areas. I would certainly not say that it was negotiating in bad faith.

Mr Owens: Madam Chair, I must state that I am quite impressed with the amount of latitude you have allowed the committee to have with respect to questions.

The Chair: What I have done, Mr Owens, is try to divide the time equally among the three caucuses. We have until 5:20 to complete the amount of time.

Mr Owens: My question is with respect to OCUFA and other such interested parties. You indicated that discussions had been ongoing. Will those discussions take place with respect to their concerns around faculty and tenure and other such related issues that they have an interest in?

Dr Wyman: Yes sir, they would.

The Chair: We have until 5:20, which is approximately three more minutes, to complete the time allotted for the presentation, and I have two requests, one from Mrs Fawcett, one from Mr Hope. Can you each try and take one minute?

Mr Hope: One is no problem.

Mrs Fawcett: Thank you, Madam Chair, I appreciate that. Being a brand-new member to this committee, I am

trying to comprehend as much as possible. I am just wondering, what is the budget for the joint management committee? Does anyone have an idea on that budget?

Dr Wyman: I am not sure it is clear yet what the budget requirements will be. The JMC has just begun to meet. There have been discussions about developing a substructure to provide the research requirements for it. It will be meeting on a monthly basis with the costs for each side being borne by each side.

Mrs Fawcett: On a 50-50 cost-sharing basis?

Dr Wyman: We would each bear our own costs, yes. As the program of the joint management committee develops, I think we are going to have to find what the budget will be as it grows in terms of its involvement in public policy. At this point it is impossible to tell what the extent of the cost will be.

Mrs Fawcett: So that will be decided when you get the plans done and as it goes on.

Dr Wyman: Yes.

Mr Hope: Before I get on, I am totally in favour of the principle of the Rand formula. I hear a lot of allegations about southwestern Ontario being so fully medicalized; I must say that we are not. Coming from a rural area of southwestern Ontario, Chatham, we are missing a lot of services which are provided in the larger centres.

Through this bill you are the representative body of the profession, whether it be a union, as some people have a hard time saying. How can the underserved areas, which are really not identified by Northern Life or whatever, in southwestern Ontario play an active role in making sure that the concerns of their communities are brought to your attention so that you can work jointly with the government in bringing those to light? My concern is that you being the representative body, if I have concerns in my area—and the doctors do have concerns about getting the specialists into my area—how can I use that as an active way of getting our concerns into your organization?

Dr Wyman: Within the Ontario Medical Association we have an additional structure process to the one I identified previously, which involves sections of physicians who have like interests. We have a section of rural practice; we have sections of family practice; we have sections of specialty interests. Through those areas, any problems of maldistribution of services will come to light. The people who function in the areas we often refer to as being underserved are not classified by the government as being part of the underserved areas program. A large number of those that are not covered will bring their plight to our attention.

We also have a regional representation, as I have identified, that will allow those members from the southwestern Ontario region and from central Ontario and other areas help to bring that forward. There are also local medical societies, for example Kent County Medical Society, that will look after local issues and again bring that through to the central organizational structure.

We are looking forward to being able to help resolve some of these issues through the joint management process.

The Chair: Thank you very much for your presentation today. We appreciate your coming before the committee. As you have heard me mention to other presenters, the committee will be dealing with this bill tomorrow, and if there is any additional information you think would be helpful to the committee, we ask that you submit it tomorrow in writing before 3:30.

Dr Wyman: Thank you, Madam Chair.

The Chair: Thank you very much. We had a request from another group that wished to make a presentation to the committee. I do not have the names of the individuals. Is there anyone here at this time who would like to make further representation to the committee on Bill 135? Last call.

Is that it? I can only assume that those individuals who had asked to appear before the committee today were unable to come. If they happen to be watching the presentation, and for anyone else who is viewing, as I have mentioned before, the committee will be dealing with this legislation tomorrow beginning at 3:30. If there is anyone who wants to let the committee know how he feels about it, I suggest he communicate in writing to our clerk prior to the beginning of the hearing, which will be at 3:30 tomorrow afternoon.

The committee formally stands adjourned. However, there will be a meeting of the subcommittee immediately following the formal part of this meeting.

The committee adjourned at 1722.

CONTENTS

Monday 2 December 1991

Election of Vice-Chair	S-931
Subcommittee report	S-931
Ontario Medical Association Dues Act, 1991, Bill 135	S-931
Ontario Confederation of University Faculty Associations	S-931
Sudbury and District Medical Society	S-935

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

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Wessenger, Paul (Simcoe Centre NDP)
Wilson, Jim (Simcoe West PC)
Witmer, Elizabeth (Waterloo North PC)

Substitutions:
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Mammoliti, George (Yorkview NDP) for Ms Haeck

Also taking part: Brown, Michael A. (Algoma-Manitoulin L)

Clerk: Mellor, Lynn

Staff: Drummond, Alison, Research Officer, Legislative Research Service



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Legislative Assembly of Ontario

First Session, 35th Parliament

Official Report of Debates (Hansard)

Tuesday 3 December 1991

Standing committee on social development

Ontario Medical Association
Dues Act, 1991

Assemblée législative de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le mardi 3 décembre 1991

Comité permanent des affaires sociales

Loi de 1991 sur les cotisations
de l'Ontario Medical Association



Chair: Elinor Caplan
Clerk: Lynn Mellor

Présidente : Elinor Caplan
Greffière : Lynn Mellor

Published by the Legislative Assembly of Ontario
Editor of Debates: Don Cameron



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Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 3 December 1991

The committee met at 1541 in room 151.

ONTARIO MEDICAL ASSOCIATION DUES ACT, 1991

LOI DE 1991 SUR LES COTISATIONS DE L'ONTARIO MEDICAL ASSOCIATION

Resuming consideration of Bill 135, An Act to provide for the Payment of Physicians' Dues and Other Amounts to the Ontario Medical Association / Projet de loi 135, Loi prévoyant le paiement des cotisations des médecins et d'autres montants à l'Ontario Medical Association.

The Chair: I see a quorum. We are dealing today with clause-by-clause consideration of Bill 135. We had agreed we would have a subcommittee meeting at the start of this day's work, but I think in light of the fact of attendance we might want to do that at the end of clause-by-clause consideration, if that is acceptable.

Mr Hope: I take it nobody is listening to you, Elinor.

The Chair: That is normal. I am quite used to that, but it is all in Hansard and on the record, so when I tell you what I think everyone has agreed to, a consensus, who is to argue since nobody paid any attention, right, Mr Hope? So we will agree to do that. All agreed? That is fine.

We will begin now with clause-by-clause consideration of Bill 135, An Act to provide for the Payment of Physicians' Dues and Other Amounts to the Ontario Medical Association. We had our presentations yesterday and we are now prepared to begin clause-by-clause consideration.

Section 1:

The Chair: We have notice of one amendment to section 1.

Mr J. Wilson moves that section 1 of the bill be amended by adding the following subsection:

"(3) This act does not apply to physicians who are represented by a bargaining unit, whether certified under the Labour Relations Act or not, that represents faculty at an Ontario university unless the bargaining unit and the Ontario Medical Association agree that this act shall apply to those physicians."

Mr J. Wilson: I have reviewed the letters of today submitted by both the Ontario Confederation of University Faculty Associations and the Ontario Medical Association, and we still believe the amendment is appropriate. Our amendment was developed through consultation with OCUFA, which represents in excess of 12,000 people, because we felt and it had come to our attention that the OMA had not consulted the faculty association in coming up with Bill 135 in consultation with the government.

We believe Bill 135 removes the right of bargaining from the legally constituted faculty bargaining units at each of the five Ontario medical schools, and I reiterate the fact that on this point OCUFA was a witness before the

committee yesterday and indicated to all the committee members that they were not consulted on this matter. OCUFA maintains that it is an illegal raid of faculty bargaining units, and that fact is disputed by the OMA, to be fair to them.

Prior to the agreement to obtain bargaining rights and representation rights for positions in the university sector, the OMA had to serve notice to bargain, and that was brought out in OCUFA's brief yesterday. Following this, the employing agency of a member of the unit being claimed could challenge the OMA to demonstrate that it represents those physicians. Where the OMA demonstrates it has more than 50% membership in the unit, it could bargain on matters affecting compensation and other matters agreed to by the parties. In the case of absence of an agreement, they have the right to go to mediation and arbitration.

We believe the negotiation of jurisdictional issues and membership fees and issues should be local in nature due to the wide variation of circumstances at each of the medical schools at the universities. We are not asking that the OMA should be replaced in its role of negotiating fees for service of faculty members, but we are asking that the traditional role faculty associations have had in the past continue, and faculty associations have traditionally represented faculty on all academic and policy issues in academe.

Mr Owens: I do not think it is any surprise to the members of the third party as well as the official opposition, but our party will not be supporting the amendment put forward by the third party.

On the face of the amendment it looks entirely reasonable, and I think we heard yesterday that there seems to be an issue where one says there was no consultation and the other says there was consultation. I cannot believe there was no consultation taking place between the two groups. As a matter of fact, I think there was agreement. There were discussions up until even shortly before these hearings began around the issue of how the two groups can continue to coexist and how they will continue to coexist, as they have in the past.

I think in terms of the letters both groups have set before us here today, the OMA is undertaking a specific area of negotiations and OCUFA has clearly a different community of interest. I think they were quite clear yesterday in setting out what their interest is, and it is my understanding that their interest is clearly around issues of tenure and academic excellence.

I do not believe the OMA is uninterested in these areas, but in terms of what the OMA's role is in this process, it has set it out quite clearly under point 1 of its letter, "(a) fee-for-service negotiations; (b) the CMPA benefits"—which are the Canadian Medical Protective Association benefits, the insurance program physicians must participate

in—“(c) alternative funding arrangements; (d) JMC; (e) health policy.”

The OMA has, I believe, demonstrated good faith, and it has clearly stated its intention, as I say, to continue discussions with organizations like OCUFA because, again, there are issues OCUFA is interested in carrying out that, while the OMA perhaps is interested, it is not currently equipped to do.

I think some of the other concerns that were brought up yesterday were interesting concerns. The issue of underserved areas in the north is clearly an issue that all three parties have struggled with in order to provide efficacious health care to northern Ontario, but I do not feel it is related to the bill.

I guess in closing, Madam Chair—you are looking at me with that look that tells me I should close.

The Chair: “Efficacious” is a very good word, Mr Owens.

Mr Owens: That is right. I was also going to say that unlike the member for the third party, I believe in speaking extemporaneously rather than using prepared remarks.

The Chair: Now, now, do not provoke.

Mr J. Wilson: Your parliamentary assistant—

The Chair: No, order. I am sorry I interjected with praise on the term “efficacious.” Please continue.

Mr J. Wilson: I would like to speak extemporaneously for just a few minutes here, Madam Chair. I would be happy to. I thought I would show restraint and stick to my notes for a change.

The Chair: Order. Mr Wilson, if you wish to speak I will put you on the speaker's list.

Mr Owens: The praise, as I say, is well taken and I will certainly undertake to use that on my next election leaflet. But in closing, as I stated at the outset, the government will not be supporting the motion put forward by the third party for the reasons I have set out.

The Chair: Thank you, Mr Owens. Mr Wilson, if you insist.

Mr J. Wilson: I will show restraint and speak to the committee without notes. I do note in the OMA letter that they very much feel that extending the Rand formula to physicians and faculty members at the medical schools in no way constitutes a raid on members of those bargaining units.

I guess where I have problems in understanding that it would not constitute a raid is the fact that when you extend the Rand formula to those people, those physicians will now have to pay substantial OMA dues. Their membership in the faculty association is voluntary, as is the fee paid for that membership. OCUFA is very concerned that now that those physicians will absolutely have to pay OMA dues, whether they are practising outside the university or not—and you will note in OCUFA's letter that not all physicians earn the majority of their money through fee-for-service billings, that some physicians in the province who are members of the faculties at universities receive a large portion of their income through their teaching and activities and research at the universities—they will have to pay a substantial, very high OMA due. OCUFA is very worried that

because they have to do that as a result of this bill, they will no longer be voluntary members of the faculty associations and will not pay those fees. They see that as a raid on the faculty association.

The Chair: Thank you, Mr Wilson, for your extemporaneous remarks. Mrs Cunningham?

Mrs Cunningham: I have a question, Madam Chair, if that is appropriate.

The Chair: A question only of the parliamentary assistant.

Mrs Cunningham: That is fine. That is exactly whom I will be asking it of. Since there are faculty associations who have physician members who receive none of their income due to the OMA's efforts who will now be paying OMA dues, I would ask this question: Was OCUFA represented at the bargaining table during the deliberations of this agreement?

Mr Wessinger: I am afraid I do not understand the question.

Mrs Cunningham: I am just responding to what Mr Owens said. He found it hard to believe the groups had not been represented at the bargaining table.

Mr Owens: I said “consulted”, not “represented.”

The Chair: Mr Owens, I will put you down and you can have the floor, but you cannot interject.

Mr Owens: I want to make sure—

The Chair: If you want to put on the record whatever, it is acceptable and I am happy to put you down.

Mrs Cunningham: If Mr Owens did say “consulted”, then I would still let my question stand. It is not my understanding that when you have people in any bargaining unit who have nothing to gain from that unit, in fact they would not be represented at the table in some way. But my question is very clear: Was OCUFA represented at the table during the collective bargaining of the OMA agreement?

1550

Mr Wessinger: My understanding was that the bargaining was between the Ontario Medical Association and the government of Ontario and no other body.

Mrs Cunningham: I consider the seriousness of the discussions yesterday. Since they were saying they were not represented, somebody could have answered the question. I think it is a simple question.

The Chair: And your question is?

Mrs Cunningham: Well, I do not like the answer. I asked a specific question. I asked if they were represented.

Mr Wessinger: I think it should be pointed out—

The Chair: No, just a minute. To be fair, you are entitled to ask your question. Mr Wessinger, on behalf of the government, answered your question. It is not any point of order before this committee whether you like the answer or not, but the answer was given.

Mrs Cunningham: Maybe he would like to have another chance. It looked like he did.

Mr Wessinger: The only thing I would like to say is that 80% of them are members of the Ontario Medical

Association. Those figures were given. In effect, 80% of the persons teaching in the medical faculties in the universities are members of the Ontario Medical Association. I think it is fair to say there was representation in that manner, not OCUFA specifically.

Mrs Cunningham: I think Mr Wessenger understood my question and has just answered it—"not OCUFA specifically." That is a fair response. That is part of the concern. In looking at both of the letters, from OCUFA and the OMA, in the future one ought to take a look at the makeup of the bargaining unit if there are divergent interests, at least in this regard.

Specifically, that is why we had the matter referred to the committee. We felt, given the concerns of the faculty associations, that the government had not clearly understood why they felt they were left out. That is why we asked that this bill be referred, for that specific reason. We did not want to get into any other issues. In fairness, since it is a very large concern on behalf of a lot of individuals who did not feel they were properly represented, I think that in the future the government ought to take a look at that in conjunction with the Ontario Medical Association. I do not think it is good in this province to have those kinds of hard feelings with people within bargaining units.

The leadership has to come from someplace and it should be coming from this government. My colleague Mr Wilson has certainly put on the record the reasons we have put forward our amendment. I am not certain that in his response Mr Owens understood why we wanted that amendment put forth. I do not think it is good enough to say that there was appropriate consultation. What we should be talking about, and he is as aware as I am of the makeup of collective bargaining teams, is that some members said they did not feel they were consulted and, more important, not represented.

We should be listening clearly to that and taking some direction back to one of the partners in these negotiations. Since this divergent point of view has come forth and people feel this is not a fair agreement, where in fact they have not been properly represented and where their fees will be deducted, although in fact they do not bill through the OMA, I think that is serious business and the government should consider it for future negotiations.

Mr Owens: Just to begin by correcting the record, Mrs Cunningham, the member for the third party has suggested that I had indicated that OCUFA and other parties were represented. In fact, I said "consulted." In terms of not understanding why the third party has put forward its amendment I think is not realistic. I understand why the amendment is there. Coming from a labour organization and participating in collective bargaining, I think I have a fairly intimate knowledge of how bargaining works. I can tell you that we were not able to please each and every one of the 1,100 members we had the pleasure of serving, and we strove to match communities of interest as best as possible. I understand that there are people who probably feel that the process was not fair or that they were not represented appropriately.

I think the message has been made quite clear through the joint management committee and through the promise, made here by the OMA yesterday, that the consultations will continue with OCUFA. This is not the end of a relationship. I have faith that will be carried forward. If for some reason it is not carried forward, then I would invite OCUFA to write to me or the minister to indicate that the relationship is not being carried out in good faith. I believe both parties have a duty to carry out the agreement in good faith.

The reason we are here is that we have a piece of legislation flowing from the agreement. Again, I have no reason to believe that parties were not consulted throughout the process. We have an individual here from the ministry who was involved in that process. If I am wrong, I invite that person from the ministry to correct me.

Mr Hope: Just quickly, looking at all the submissions today and also the amendment that is being put forward by the Conservative Party, one of the problems you get into under master bargaining of collective agreements, and one of the problems that is being faced here, is an association that is not identified as a true bargaining agent. Yes, you may be a spokesperson on behalf of a group of individuals, but no certification of that nature is a proven jurisdictional right.

Coming from the auto sector, when I look at this and read the comments put forward, one of the comments that you get under master bargaining is that you can still have workplace bargaining units that enhance programs and enhance benefits for their members. What I see in the amendment that is being put forward deletes that so-called global bargaining aspect. What I see in the government bill, and what I am reading also from the OMA, is still the enhancement. There will be a relationship on the workplace or faculty members' bargaining rights as to expand programs.

Unfortunately, as one who has experienced it, I know you can never please everybody through the collective bargaining process. But one of the very important ingredients of it is to have additional workplace representatives, which means you can enhance programs.

The faculty association says that some can receive from 5% to 85%. There is a receivable there, and it may be not to the benefit most people would like. In order to share the fruit of the tree, you must pay a small portion. But you can still have the enhancement of workplace organizations that will enhance the collective bargaining process and cover the areas not covered by the OMA.

So when I look at the amendment being put forward by the Conservative Party, I have a hard time understanding how, if you are not identified under the Labour Relations Act, you know where the jurisdictions are. The jurisdictions have to be clear. I believe identification and certification may be the appropriate steps to take. Then you would be able to clearly define each other's roles. But it is not there. With associations you have the significant problem of who the actual representative is, whether it be voluntary dues or not. It is still very hard to prove who has the right to be the collective spokesperson on behalf of the individuals.

I believe the OMA, because we have just gotten done dealing with the health professions regulations, which fall under that total umbrella, the OMA has the right to represent the total physicians of this nature under the collective

bargaining process. Hopefully, after this legislation is passed, the organizations and other organizations that may not have had the opportunity to be here today will come together in co-operation to form, I guess, one house of labour and from there branch off to workplace representation or regional representation. I am very confident that the two will get together to resolve their differences in an open and honest fashion.

1600

Mr Wessenger: I would like to respond to a few of the comments made. First of all, I think the problem is one that has been presented to us by the leadership of OCUFA and not really by the physicians who are in teaching. There has been no indication that any physician who is in a teaching position is dissatisfied with the OMA representatives.

Mr J. Wilson: That is untrue. They stated yesterday who they were representing.

The Chair: Order. Mr Wessenger is entitled to have the floor and I ask for your co-operation. You will have the opportunity to express your views when you have the floor.

Mr Wessenger: The other thing I would like to indicate is that OCUFA and OMA did consult formally after the master agreement was signed and have been consulting up until now to try to work out an agreement. Certainly it has been the indication of the OMA that it is prepared to co-operate with OCUFA, and we certainly hope it will co-operate with it.

Last, with respect to the doctors and health science centres, they were consulted and were a key constituency in approving and supporting the agreement with the OMA.

A comment was made with respect to the high level of fees. The OMA fees are variable, from the highest fees, which I believe are around \$1,100, to much lower fees; for instance, \$350 for those on a salary and down to zero for missionary doctors. They do have a variable fee structure which could take account of the situation of physicians in the teaching area.

Mrs Cunningham: I am glad I am going after Mr Wessenger, because I think his remarks are contradictory. First of all, OCUFA clearly represents members of faculty associations, many of whom are medical doctors and who teach in medical schools. It is that simple. They just do, so to say they do not does not make any sense.

Mr Hope: They do not.

Mr J. Wilson: No, the OMA is now moving in.

Mrs Cunningham: There seems to be some misunderstanding about this. I would like it clarified. I would like Mr Wessenger to clarify his first point.

Mr Wessenger: The indication I had from the OMA was that physicians are generally represented by their own associations in the medical school. The OMA indicated to us that it had no complaints from any physicians with respect to—so I am basing on the representation made at the hearing and what the OMA said. I am taking their words. They indicated—

Mrs Cunningham: They had no complaints?

Mr Wessenger: They had no complaints from any of their physicians with respect—

Mrs Cunningham: I just wonder if I am the only one who is getting complaints. Is that not interesting? I cannot imagine the people who are phoning me and complaining about this legislation so that we bring this amendment forth have not also contacted the OMA. It does not make any sense, especially given the letter from OCUFA. It was sent to the Chair of the committee. Surely, if they have been having meetings and trying to get this thing worked out on their own, they have been complaining to the OMA. Is that not why they are having meetings? Because these faculty members are not happy, they are trying to come to some conclusion on their own, which I support, by the way. But do not say they have not complained to the OMA. That is what they are meeting about.

Mr Wessenger: Well—

The Chair: I suggest to you, Mr Wessenger, that Mrs Cunningham's questions are rhetorical. You do not have the floor; she does.

Mrs Cunningham: He does not have what?

The Chair: He does not have the floor; you do.

Mr Wessenger: Rhetorical questions, okay.

Mrs Cunningham: Yes, I suppose you are right on that. I cannot imagine people meeting over something they do not agree about and not having complained to each other. That is all, so I think that is simple. Then Mr Wessenger proceeded to say that they were consulted after the agreement had been signed. I will not ask a rhetorical question. I will ask, if that is the case, is that not why we are here?

Mr Wessenger: The OMA has been attempting to work out an agreement with OCUFA with respect to the situation concerning the faculty. I understand they want to reach an agreement and I understand they were close to reaching an agreement, but they broke up at the last moment. Certainly I hope they will reach an agreement.

Mrs Cunningham: So do I.

Mr Wessenger: I think that is the proper way it should proceed.

Mr J. Wilson: Well—

The Chair: Mr Wessenger has the floor.

Mr Wessenger: I have the floor. That is certainly the way that we see the matter should be dealt with and I am confident the OMA will work out an agreement.

Mrs Cunningham: That is why we have the amendment, clearly supporting what you have just said. "Unless the bargaining unit and the Ontario Medical Association agree that this act shall apply to those physicians"—that is what we have said. They have certainly got lots of room to negotiate after this goes through. They can even negotiate how it will affect each faculty association. That is what we are trying to do today.

Madam Chairman, I would like to speak to my colleagues Mr Owens and Mr Hope.

The Chair: You can place your comments on the record; you cannot ask them questions.

Mrs Cunningham: I will not ask them questions. It makes me nervous to ask them questions some days.

Mr Owens: On a point of privilege, Madam Chairman: That was completely inappropriate.

Mrs Cunningham: Why? If you feel nervous, you can say it.

The Chair: Mr Owens, that is not a point of privilege. Thank you for the interjection. Mrs Cunningham has the floor.

Mrs Cunningham: If I feel nervous, I will say it. You can say the same thing to me.

The Chair: I will put you on the speakers' list if you wish to speak.

Mrs Cunningham: I cannot believe I am sitting here listening to people lecture us on what they know about collective bargaining. A lot of us are involved in collective bargaining. That is one of the reasons I am here right now. When you talk about the makeup of teams and who represents whom at the table, the bargaining agent or whatever you want to say, I can tell you right now that I have been involved in negotiations, if you want to talk about teachers' collective bargaining, where at the table psychologists are represented, teaching assistants are represented, teachers are represented, principals are represented and vice-principals are represented.

The only point I was making was that, this time at the bargaining table here with the OMA, perhaps it would be a good idea, since there is such dissatisfaction that the faculty members who have never paid dues and who in fact have never billed—I want to make sure I get this right here. There are faculty association physician members who receive none of their income due to the OMA's efforts. Those people perhaps should be represented right at the table. That is the only point I am making.

If you want to go on, I have also negotiated with CUPE, by the way, on both sides of the table, given the long life I have led, where in fact executive assistants, secretaries, clerks and teaching assistants have all been represented at the CUPE negotiations. I have also negotiated with OPSEU where in fact child care workers, maintenance workers and kitchen staff have been represented. I could go on and on. That was the only thing I meant.

If you are going to represent somebody who gets nothing from paying the dues, he or she should have a voice. If they have not been consulted—and the parliamentary assistant said to us that they were consulted after. He said that, I did not, because I had thought they were consulted before. But I am talking about represented. I do not want to be so presumptuous to say this is what OCUFA even wants. I am just raising it in response to some observations here. I am not even going to be so presumptuous to say that the OMA would want this; maybe it would. I do not know what the best makeup is, but somebody was left out and all I want is for the government to recognize that, and that is why we are here in this committee.

There are ongoing discussions and I hope some conclusion is reached that everybody can agree on. In the meantime, we have brought forth the amendment that OCUFA has asked us to bring forward because it thinks it would solve the problem. They obviously have not been able to solve it on their own. The government knows that

OCUFA, especially these faculty members who receive none of their income due to the OMA's efforts, are being affected during the bargaining process. As people who have been part of the bargaining process, Mr Owens and Mr Hope can imagine how these people feel. You have to believe they must feel just awful, that all of a sudden somebody is going to ask them to pay dues and yet, as a matter of fact, they do not gain any benefit from it at all. As people who are part of the labour movement, they must have some sympathy for this.

I see Mr Hope shaking his head. I am glad Mr Owens is not, because in fact those are the people whose concerns we are bringing to this committee meeting today.

1610

Mr Owens: I am shaking my head now.

Mrs Cunningham: That is fine, Mr Owens is shaking his head, just for the record. Some days you just wish you had never bothered. But there ought to be a little more understanding of a real problem here today. I do not mind that the government members are not going to support it; they get their marching orders. They were going to be new and different, but they are not new and different. So next time out, you guys can kiss your seats goodbye. That is the way I look at it.

The Chair: Thank you, Mrs Cunningham. Mr Wilson.

Mr J. Wilson: Just to add to that, I think the government members have to understand why faculty members are so very angry at this government and why this is one more infringement upon their rights. You have been tough on faculty members and in the RHPA, the Regulated Health Professions Act, you axed two of them from the council of the College of Physicians and Surgeons of Ontario. We went from a representative from each of the five medical schools down to three. They were angry about that. You have had absolutely massive cuts to the transfer payments to universities. They are angry about that.

I think for the public out there, what we tend to forget is that medical doctors, physicians, get their licences—we still use the terminology "licence," but their authority to practise medicine in this province comes from the College of Physicians and Surgeons of Ontario. The OMA has clearly strong-armed the government, as they used to do to us in the old days, and convinced you that they should move in now and extend the Rand formula in a heavy-handed manner to people in the faculty associations who would like an agreement made ahead of time before heavy-handed legislation is brought down, and that is all our amendment does.

You have the cart before the horse here. You have the legislation coming in in a heavy-handed way, and yet our amendment clearly says they should sit down and come to an agreement before the Rand formula is extended to those members who have complained to our offices, or we would not have been going through this exercise.

Our amendment speaks to agreement. I think it is absolutely consistent with the logic put forward a few minutes ago by the parliamentary assistant. He talked about the fact that there should be agreement. This says, "Don't put the cart before the horse. Come to agreement, and when they

agree that those faculty members should have the Rand formula extended to them and should pay OMA dues," then that is fine. I do not see the need for a rush, and it just flies in the face of what your candidates said and what I am sure many of you said and what your Premier says almost daily in the Legislature about partnerships and fairness and agreements and consultation.

We think it is a very reasonable amendment that we have brought in and we would ask you to reconsider your position.

The Chair: Just for the information of members of committee, I have the following speakers' list: Mrs Sullivan, Mr Owens, Mr Hope, Mr Sola and Ms Haecck. Mrs Sullivan, you have the floor.

Mrs Sullivan: There are a couple of areas that are distressing about the bill and why we see the amendment proposed by the Progressive Conservatives as having some merit and I want to review those.

Indeed it has been pointed out that for many physicians practising at the university and working in a university setting, the primary relationship of those physicians is to the university and the primary bargaining questions for those physicians relate to academic issues that are faced by academics in other faculties. They relate to issues of tenure, promotions, student population and questions of standards of operation. Those are issues where OCUFA indicated to us yesterday that it felt there was no particular expertise or qualification exhibited in the past by the OMA in representing that group of physicians.

In the course of looking at where the bargaining has been recognized—and I am sure that when this negotiation process between the OMA and the Ministry of Health was being undertaken, it probably did not occur to a health researcher, by example, at the University of Western Ontario, that the impact of an agreement about which there was very little information would in fact affect his operation and his representation with his university and in its own faculty associations.

At every single one of the five teaching universities we see that there have been formal agreements from the universities indicating who shall represent the university teachers. In Ottawa that agreement has been formalized since 1975—I am just referring back to notes—in Toronto since 1977. At the University of Western Ontario, since 1971 there was an informal agreement and that agreement was formalized in 1985. At Queen's the formal agreement has been recognized since 1976. This is not a new approach.

I think what is interesting and in fact problematical with the legislation as it is put forward is that the people who had been represented in a formal bargaining mechanism by OCUFA or the faculty associations at the particular universities were not consulted and were not involved. Many of them may not have been members of the OMA and therefore would not have even been able to participate in the vote, whether in a full vote or through the proxy methodology that was put forward.

One of the things that struck me about the OCUFA presentation yesterday was that they indicated they were not fundamentally opposed to joint representation in certain

areas. It seems to me that the Conservative amendment that is being put forward provides the opportunity for that joint representation. So the academic matters, the matters of specific academic policy, can receive full representation by OCUFA or the particular individual university associations, and the OMA can participate in matters relating to the fee-for-service and other issues where the OMA has expertise and has represented physicians who work in a multi-setting and who are bargaining in a different environment and with a different person on the other side of the table.

It seems to me that this amendment provides that flexibility. I would be very interested in seeing if Mr Wessinger sees that the flexibility is indeed necessary due to the different kind of work environment and work-related concerns of two different kinds of practising physicians and indeed if he can see the flexibility in this amendment as it is put forward to deal with both of those issues.

The Chair: Thank you, Mrs Sullivan. Mr Owens, you have the floor.

Mr Owens: I listened with particular interest to Mr Wilson's comments around—

Mrs Sullivan: On a point of order, Madam Chair: I think I have a question for Mr Wessinger.

The Chair: I will put you back on the list, Mrs Sullivan.

Mrs Sullivan: I did ask a question. I asked him if he could see the flexibility in the amendment to cover those two situations. I would like to hear him comment.

The Chair: You were not clear and in directing that to Mr Wessinger. I will allow him to answer and then you will have the floor, Mr Owens.

Mr Wessinger: First of all, with respect to the amendment, I think the amendment put forward by the Conservatives would put the government in breach of its agreement with the Ontario Medical Association and would make us bargain in bad faith. We have an obligation to support the agreement, and this bill is supporting that agreement. That is the first comment I would like to make.

The second comment I would like to make is I agree that, for the situation involving the general comment with respect to the physicians who are faculty members, certainly the OMA has to work, or should work, in co-operation with OCUFA with respect to those areas, particularly the areas of tenure that you mentioned. I am hopeful an agreement will be entered into between OCUFA and the OMA to deal with these matters.

Last, I would like to say that the amendment, aside from the other two matters, in effect weights the bargaining power on the side of OCUFA. It is not an evenhanded amendment; it, in effect, gives OCUFA the upper hand in bargaining with the OMA. I would not support that for that reason, besides the others.

1620

The Chair: Mrs Sullivan, you still have the floor.

Mrs Sullivan: Thank you. On your first point in relation to the question of the government having the obligation to fulfil the agreement with the Ontario Medical Association, there are very serious questions being raised at this point already as to whether indeed the government is fulfilling

the agreement as it was written. They are coming in relation to exemptions, relating to doctors who are providing services in underserved areas, to doctors who have been refused exemptions in certain geographical areas, which it was very clear to us yesterday the OMA had not expected. There appears to be some concern about whether indeed the government is living up to its obligations to fulfil the agreement in terms of the funding of the joint management committee. There have been very unclear approaches and announcements made in those areas.

One of the questions, of course, I put to you is whether a flexible approach, which was requested by OCUFA, was the appropriate approach, in that those university-related issues affecting only university-paid doctors should not be addressed by those associations who represent university physicians as well as other academics who are in similar situations. Once again, for the OMA expertise—fee-for-service areas—the flexibility could be provided without giving anyone an upper hand.

The amendment is, “unless the bargaining unit and the Ontario Medical Association agree.” There is not question of an upper hand. It says “agree.” It seems to me that that agreement could be on joint representation, with the OMA representing physicians who belong to faculties in relation to fee-for-service and other matters where the OMA has specific expertise, and the faculty associations could represent those physicians who have particular interest and particular requirements in relation to their academic functions in a university setting. This says, “unless the bargaining unit and the Ontario Medical Association agree.” Agreement does not give one or the other an upper hand.

Mr Owens: In terms of the comments made by Mr Wilson around the issue of transfer payments and people being really angry with us, I find it passing strange that as I was reading my *Globe and Mail* this morning there was an ad from OCUFA asking people to clip the coupon suggesting to the Premier that they were mad about university underfunding. However, if you look at the text of the ad it also said that they want us to make up for 15 years of underfunding by previous governments. So I think that in terms of putting the responsibility squarely on our shoulders, that is not—

Mrs Cunningham: That is why you were elected, Steve.

The Chair: Order. Mrs Cunningham, I can—

Mr Owens: I am trying to inject a little reality and little bit—

The Chair: I am sorry. Mr Owens, just a moment, please. I am happy to put you on the speakers' list, but you cannot interject.

Mrs Cunningham: Put me on the speakers' list.

The Chair: When another member has the floor, I am going to request that you—

Mr J. Wilson: If you chide us with thought-provoking comments—

The Chair: Mr Wilson, you are on the list. Mr Owens, I would recommend that you not tease the bears or provoke the members of the opposition.

Mr Owens: I think the phrase is, “Don't tease the bears”—

Interjections.

The Chair: Order. No, I cannot allow that. When a member has the floor, other members are not permitted to interject. You can ask to be placed on the speakers' list, but Mr Owens has the floor and is entitled to speak. You may continue, Mr Owens.

Mr Owens: In terms of the issues Mrs Cunningham raised with respect to her not wishing to be lectured on collective bargaining, it certainly was not my intent to provide the ABCs of collective bargaining. With the fairly extensive experience Mrs Cunningham outlined to us with respect to her experience with unions, both, I am assuming, on the union side as well as on management side, that Mrs Cunningham understands that, while we—

Interjection.

Mr Owens: No, let me finish—that we understand that, while we strive to have each and every party represented, that is not necessarily what happens and that we attempt to negotiate in good faith the best agreement possible. The issue that was raised by Mrs Sullivan with respect to underfunding of the joint management committee—and I pose this question to the parliamentary assistant: It is my understanding that each party will fund its own costs on the joint management committee. Is that not a correct understanding?

Mr Wessinger: Yes, it is a correct understanding. If I might comment, the Ontario Medical Association has published in its OMA Review that the government has been positive and supportive of the joint management committee and its development. The joint management committee is just starting. There have been two meetings held and seven more booked.

Mr J. Wilson: Are those comments extemporaneous?

The Chair: Thank you very much for your interjection, Mr Wilson. You are on the list, but not right now.

Mr Owens: Madam Chairman, I suppose we are probably going to go around the room for the rest of the afternoon debating who has more bargaining experience and who understands unions more and how the—

The Chair: I think Mrs Cunningham might concede the point if you would stop speaking to it, Mr Owens.

Mr Owens: Anyway, I thank you, Madam Chair.

Mr Solá: Actually, my point has been made by Mrs Sullivan, but I would just like to make a comment. I am a little perturbed by the attitude of the government. I have only been sitting on this committee for a day, and I specifically remember Mr Owens posing questions to both parties yesterday—OCUFA and the Sudbury and District Medical Society—as to whether or not they were consulted during the bargaining process. He got a clear, distinct, definite “no” from both parties. As a matter of fact, OCUFA even had members of a couple of faculty associations here who distinctly and adamantly said they were not consulted. For him to conclude, because the OMA declared that consultation did take place, that therefore consultation was the order of the day, I find difficult to understand. But then, after the comments by the parliamentary assistant that discussion

after the fact can be taken as consultation, I am afraid there is going to have to be a change in attitude if we expect the OMA will have control of these dissenting members.

1630

Ms Haeck: As probably many professionals out there do, I for one have not only a professional association; I also, in my other life as a public librarian, had a union association. I am quite sure it can be said that among the faculty—and obviously 85% of the faculty who are teaching at Ontario's medical schools have a similar type of arrangement—those relationships are not—how shall I say?—conflicting. They may perform somewhat different functions, as in the faculty association assisting with bargaining with the university and obviously looking after whatever moneys or salaries the professors may gain from the university and the OMA providing whatever salaries, fees, coming from OHIP. So I really do not see this as being the kind of issue that has been purported here. The OMA, at this point, is looking after those moneys flowing from OHIP, and it is really, I think, quite that simple.

The Chair: I have on the speakers' list, just so that everyone is aware of where he or she is—and if you want on the list, please signify—Mr Hope, Mr Wilson, Mrs Cunningham, Mrs Sullivan, Mr Owens. Mr Hope, you have the floor.

Mr Hope: I certainly will not tease the bears. Just for my friend from London, who I know has been on bargaining units before and played an active role: The issue here has to be that, when you start a new process, there is always someone who is unhappy. The system will straighten itself out, as the member for London North indicated. She sat on a number of bargaining committees that had representatives from all areas. As you develop yourselves as an organization with collective rights, you develop the policy inside the framework that you have full representation. But when you start something new and you develop something new, later on as you progress into strategies of collective bargaining, you make sure that you start encompassing all areas that are subject to scrutiny.

This being a new process—and I certainly do not want to tease the bears over there—I think it is very appropriate that once the legislation is in place, the mechanisms of consultation between those different groups, or fashions or whatever you want to call them that are out there, come together in making sure that when they return to bargaining process—and in bargaining process, yes, everybody puts a wish list forward, and you come back, and you do not always have everything. You do not consult during the process of negotiations. You negotiate, in good faith, on behalf of both parties, whether it be labour or management or whether it be the government or an organization. You bargain in good faith, you make sure you encompass all the concerns that are out there of those you are representing, and you bring it back. If we are to try to straighten the process out, the process will straighten itself out after the legislation has been passed and they start to work together in a co-operative manner to make sure that the representatives of all fashions are put forward.

I am very surprised today to hear the enthusiasm of the opposition party under collective bargaining rights. I think it is great to hear the opposition member speak so highly of collective bargaining rights. I look forward to legislation on labour relations which will probably identify some of the concerns that are faced today.

Mr J. Wilson: I am surprised that Mr Hope is surprised that he somehow has this mythical vision of the Ontario PC Party not believing in the right to strike and the right to collective bargaining. Who the hell do you think brought in the legislation in the first place?

Mr Hope: Who brought in anti-scab—

The Chair: Mr Hope, you do not have the floor.

Mr J. Wilson: It was under a Conservative government. You guys do not have a corner on compassion in this province like you were trying to pretend to have in the campaign, and you do not have a collective right on bargaining in good faith.

Let's take an example in reference to this bill, because we are talking about bargaining and bargaining rights. Let's take an example of the Ontario Pharmacists' Association, where both Mr Owens, as a member of this committee, and Mr Winniger, as an NDP member from London, wrote to their own minister in the NDP cabinet and indicated that they were disappointed that the minister walked away from the bargaining process there. In fact, after an arbitrator had been appointed, after negotiations were going on, the NDP government, which is so high-and-mighty all the time on behalf of unions and collective bargaining in the process, walked away from the table unilaterally and did not even have the courtesy to speak directly to the OPA, Ontario Pharmacists' Association. The minister sent them a letter that said: "We are not going to debate your dispensing fees any more for this fiscal year. See me next year."

You have a bit of a selective memory, I think. You are certainly consistent in trying to fool the people of this province that you are on the side of the workers, but—

The Chair: I would remind you, Mr Wilson, that we are speaking to Bill 135.

Mr J. Wilson: In reference to this bill specifically, I think it is important that the people of Ontario understand that when the parliamentary assistant, in reference to this bill, says they would never bargain in bad faith, we have other examples since this government has been in office where they have done that. As Mrs Sullivan raised very clearly, we have examples within the agreement this bill refers to between the Ontario Medical Association and the government where clearly the government is not living up to its side of the bargain.

We ask you again to support our amendment. It talks about agreement before forcing the Rand formula on people who have come to us and said they do not want that forced on them until such time as they can get an agreement together with the OMA. I think it is a very reasonable approach.

I am sorry the debate has been elevated to such an emotional level, but we are all a bit guilty of getting to this plateau, but do not throw high and mighty stuff at us because we will be here all night. We are the third party, as

you are so fond of reminding us, and we have about another four years to put up with you guys. We would be happy to sit in this very room and debate constantly over the next four years whether you people actually put into practice what you preached so eloquently on the campaign trail and while in opposition for so many years.

Mrs Cunningham: I just want to add a few pieces of new information to my ongoing efforts to persuade the members of the government to vote in favour of our amendment because as I listen to them today I think they, like us, were not totally informed as to the ramifications of this agreement. I would venture to say that I bet the OMA did not realize there were people who receive none of their income due to the OMA's efforts who will be forced to pay OMA dues. My guess is they may even not have understood that when they were bargaining and I think the government may not have known it either. I am not sure whether that is fair to say, but my guess is that a lot of people got caught up in this and now we know about it we are trying to fix it.

With regard to experience in collective bargaining, since I do not know what the experience of my other colleagues on this committee from any party is, I would concede that others have a lot more experience than myself and that was not the point I was trying to make. I was just letting you know that I know something after 15 years of sitting at tables and that is the way it goes. Sometimes you have those experiences and sometimes you have others.

With regard to Mr Wessinger saying it would be bad faith, I do not think it is bad faith. If the government had the right spirit here it would work with the OMA and would have done so already by today. It would say, "Look, I think this is a fair amendment and what about it?" The good faith was extended by ourselves and the Ontario Medical Association when we had a discussion about coming to this committee.

If we had been interested in supporting any bad-faith bargaining, we would probably have encouraged others who are not happy with the agreement at all to come before this committee and we did not do that. It was not that we did not have the opportunity. We did; but we would not have asked people to come about other areas of this agreement that you can imagine everybody is not happy about. We understand that. Looking at the issues in this agreement, this is the one issue we felt was worthy of more discussion. Nobody is interested in bad faith right now. I would not expect that to be one of the points the OMA would be making, considering the very careful wording of this legislation.

With regard to new process, I am assuming that—and I will assume out loud—my first point was that no one knew they were representing people who had nothing to gain by this agreement or the makeup of the team would have been different. I am not sitting around like anybody else on this committee suggesting for one minute that we do not have enough experience in collective bargaining in this province to know who ought to be represented at the table. My guess is that no one would have guessed the ramifications of this agreement.

1640

Madam Chairman, you and I and others are extremely concerned about the cost of health care in this province. One of the reasons education, health care and social services are so expensive is that so many of the people trained to be in the front lines, whom we would like to be serving the public directly, are stuck in administrative positions trying to fix things up and deal with government intervention from time to time, day to day, minute to minute. Social service providers will say that, and so will educators, people in hospitals and the medical profession.

A good example of that is this agreement I have in front of me, "Faculty of Medicine, University of Western Ontario, An Affiliated Teacher Hospital's Academic Health Centre's"—in large print—"Plan for Staffing and Funding of Clinical Academic Units." There are 18 representatives. Another column says, "Participants." There are three. They look like representatives of the administration of the university. The others are clearly of the affiliated teaching hospitals, five of them. Assistants, people who are probably helping get all the stuff out—one, two, three; my goodness, this is administrative time. "Negotiation rights. The provisions of the recently negotiated April 1991 framework agreement between the Ontario Medical Association, OMA, and the government of Ontario have implications for the conditions of employment and compensation of contracted clinical appointees in clinical academic units."

I will not read it all into the record, but obviously these people have had numbers of meetings with numbers of recommendations as to how they deal with this agreement and the effect it has had on all these people in the teaching hospitals. These are the kinds of things that waste people's time. This stuff should have been dealt with ahead of time, either by the OMA or the government so that the people can get on with their lives and do what they are supposed to be doing: research or taking care of sick people.

I will just let you know that one of the observations that were made is that the government did not know anything about this and that people were so concerned. I do not know about the members of the government, but certainly one of the members of the government, my colleague David Winninger from London South, received a letter from the University of Western Ontario faculty association. My guess is that other members who have universities in their ridings, or perhaps faculty association members—this came on October 8, 1991. This is not new.

Mr J. Wilson: Two months ago.

Mrs Cunningham: "Dear Mr Winninger:

"I am writing to you on behalf of the faculty association of the University of Western Ontario. We are the recognized bargaining unit for all of the approximately 1,400 regular full-time faculty at the university. We negotiate salaries and benefits as well as all conditions of employment including promotion and tenure procedures, grievance procedures, terms of sabbatical etc. Included in our membership are MDs who have appointments both with medical facilities as practitioners and with the university as faculty members.

"Recently, the government came to an agreement with the Ontario Medical Association whereby the OMA would

become the sole bargaining agents for physicians, including those with university appointments."

I am reading this so that Mr Hope can hear it because he is one of the great guys who bothers about the University of Western Ontario, being one of the seven government members from southwestern Ontario who attends meetings from time to time at the University of Western Ontario to listen to their concerns. This was on the agenda of the last meeting.

"This agreement was negotiated and signed behind closed doors, with no input from the other groups which will be affected by such an agreement, including those who presently represent some of these physicians." This was sent to a member of the government.

"The result of this legislation even affects some full-time faculty members who hold an MD but who do basic research at the University with no hospital appointment." None. I would underline that.

"The association is concerned with a number of issues arising from this agreement and subsequent legislation:

"1. This agreement will generate two classes of faculty, the first being the majority of faculty whose conditions of employment affecting promotion and tenure, grievance procedures etc, as well as salary and benefits, are negotiated by the faculty association. A separate group of faculty will be represented by the OMA, thus allowing for two sets of faculty working side by side under two sets of circumstances."

Is that not why we had the Elgin county teachers' strike, because we had people working for that school board who had two different packages with regard to their retirement gratuity? Certain bargaining units were annoyed about that and therefore they have come to some conclusions where everybody is now going to be the same. Nobody likes to have two different types of people working in the same area without clearly being represented.

"Again, those MDs performing basic research will be part of the OMA's unit even though they perform no outside medical services." Can you imagine this?

"2. The NDP government, by signing this agreement, has endorsed the raiding of one recognized bargaining unit by another. We feel that this is contrary to the ideals of a political party which has aligned itself with the basic tenets of the labour movement for many years."

I have to tell you, Madam Chairman, I am not always happy with the faculty association at the University of Western Ontario. They do not often vote for me; they have told me that. Many of them are NDP members who voted for you people because you are supposed to stick up for them and work for them. I know they do not vote for me. They tell me that. They are going to vote for me the next time because I am a good listener. I bring their concerns before the committee, represent them well.

"The faculty association feels that the OMA has every right to seek bargaining power if that is the wishes of its members." I would have guessed, Madam Chairman, given the views of Mr Hope in southwestern Ontario and some of his colleagues, that he would be taking this much more seriously. "However, we believe the agreement was a product of backroom negotiation and because of this,

groups which are affected by the agreement have been given no opportunity to voice their concerns or objections."

Mr Hope is a great spokesperson of those kinds of people, and do you know what he is finding out? So are we, members of the Conservative Party and my colleagues of the Liberal Party. We all have varied backgrounds and support people who need our support and need our voice. That is what we do and we did this for years in this government and in this Legislative Assembly. It is not new that people who have been elected to this assembly for the first time would think there are those of us who only have certain points of view.

Since I have been down here in the last three years, it is very difficult to understand, at least by party, anybody who does not recognize that there are people out there who elected us so we would speak for them. Second, there are many less fortunate than ourselves. That comes from all political persuasions, which I am happy to say as a person who really supports the democratic process.

Mr Owens: This is not related to the bill.

Mrs Cunningham: Mr Owens does not like what I am saying but he had his chance and he said those kinds of things too.

Mr J. Wilson: She is reading from a letter directly referring to the bill.

Mrs Cunningham: I want Mr Owens to listen to this and he can respond to this if he wants to: "Input from the ministries of Labour and Colleges and Universities was not requested and, to the best of our knowledge, they were not informed of the agreement until after it was signed."

I am not going to speak for either of those ministries because that would not be my position to do so, but I bet you anything, Mr Wessinger will be able to speak to that because I am sure Mr Winninger shared this letter with him.

"It is even unclear to us that the physicians who are members of the OMA were aware that the OMA was attempting to change their status from a professional membership to that of a bargaining unit.

"The legislation to support this agreement, Bill 135, is presently before the Legislature and we ask that the legislation not proceed until these problems are solved."

Madam Chairman, you and I both know, because we had to discuss this amendment I was going to bring forth, that we hoped the OMA and the faculty associations being represented by OCUFA would come to some agreement before this got to committee. After all, this letter was sent to the NDP member for London South, David Winninger, on October 8.

"We count on your support"—this is to the NDP member—"for this request and trust that our concerns will be brought to the attention of the government.

"Yours truly, A.M. Dawes, President, 1991-92" of the faculty association from the University of Western Ontario.

I am just reading it into the record because I do not want to be accused of being the only person in this room who has had any complaints from people. I am sure many people are unhappy about this and they are not saying—Mr Wessinger said I was the only person, but he did in fact say they had not had a lot of concern from a government

point of view. I think when the government members got this kind of letter they must have brought it to the attention of the Minister of Health. I certainly know my colleague Mr Winninger would have done that.

1650

Mrs Sullivan: I want to address two issues, the first in regard to representation and the second in relationship to the joint management committee, and to follow up on two points. I was very interested in the argument made by Ms Haeck that in her own line of work she is a member of an association and a member of a union, and she feels the interests of those bodies are substantially different.

What I see here is membership in an association which has been recognized on every campus in Ontario where there is a medical faculty as the bargaining agent for people who belong to that association. I now see an association having been given union status: the Ontario Medical Association. Bill 135 provides de facto union status for the Ontario Medical Association.

I would like to read, because I think it describes this perfectly, subsection 44(1) of the Ontario Labour Relations Act: "Except in the construction industry...where a trade union that is the bargaining agent for employees in a bargaining unit so requests, there shall be included in the collective agreement between the trade union and the employer of the employees a provision requiring the employer to deduct from the wages of each employee in the unit affected by the collective agreement, whether or not the employee is a member of the union, the amount of the regular union dues and to remit the amount to the trade union, forthwith."

Then subsection 44(2) goes on to describe what "regular union dues" means, and of course that refers back to the Honourable Mr Justice Rand's decision in 1945 that the obligation to pay dues should tend to induce membership, one of the obligations of a union, and this in turn should promote that wider interest and control within the union. What we are talking about here are two unions and what each of them should represent their union membership on. That is what Bill 135 talks about.

Bill 135 relates not only to members of the union who are involved in fee-for-service operations. We see and we know the OMA has a statutory position: the right to bargain for fee-for-service. That is there, and it has done that. But now Bill 135 extends the provision of union membership, the obligations of a union in bargaining and the obligations of people to submit union dues, and if they do not want to belong to the union, to submit union dues to a number of other areas: to physicians who practise in insurance companies, to physicians who work in academic settings, to physicians who work in medical laboratories, to physicians who work in health service organizations and comprehensive health organizations, to physicians who work in the Workers' Compensation Board. Indeed, the provision for extension through the Rand formula is substantial. We have not had much discussion about what is happening in terms of Workers' Compensation Board physicians; we should probably talk about that a little bit.

What we now have is a situation where, for physicians who have a particular interest in a particular portion of their professional activity, representation is provided by a different union than will be provided under this legislation. The amendment put forward has provision in it that there can be joint representation. It provides the flexibility so that both issues can be covered.

I would like to step back for a minute and look at why many people joined the Ontario Medical Association in the first place. Some of them joined simply to participate in the benefits that are covered through group insurance plans. Some of them saw the Ontario Medical Association as a body which kept them up to date on medical issues—whether they were questions of ethics, whether they were questions of quality improvement—through its professional publications, through meetings under its sponsorship and so on. Membership was voluntary, and many physicians who were qualified to practise under the College of Physicians and Surgeons of Ontario chose not to join or pay dues because they may have been doing other things—for example, working for workers' compensation, working for an academic institution, working for an insurance company—where indeed the representation that affected others in the profession did not affect them.

However, now we see the OMA moving into a union status, and the OMA, in terms of its approach to the agreement, did not have certification in the normal manner other unions have: the signing of cards and the insurance that all people who were going to be on the table and included in the agreement had a say in the approach to that agreement. The proxies were designed to eliminate choice, and indeed, most of the choice was secret. I can remember as a member attempting to discover for physicians in my own riding what that OMA agreement included. It was very secret. You cannot talk about members having agreed to participate in this union, nor can we see where the university physician has been included in the discussion. They have indicated they were not included.

Mr Owens: On a point of order, Madam Chair: The subject of discussion is Bill 135. I can understand there is certainly interest in the agreement that brought us to this point, but this is not the issue we are here to discuss. I think we have heard the concerns of the opposition parties, and we have expressed concerns ourselves. However, the point Mrs Sullivan is now making is totally unrelated to Bill 135. I would suggest we go back to that subject we are mandated for. By the way, Madam Chair, we did have all-party agreement when we met as a subcommittee to complete clause-by-clause today and I am curious to know whether that agreement is going to be upheld.

The Chair: That is not a point of order, but you have had a chance to express your view. I will remind Mrs Sullivan we are speaking to Bill 135. I would also point out to all members, and to you, Mr Owens, the subcommittee suggested clause-by-clause would begin today, but I do not believe there was any time limit placed as to when it had to be completed. I will check that with the clerk.

Mrs Sullivan: I am not quite certain of the point Mr Owens was making, because indeed the agreement is an

issue here. Bill 135 is a significant portion of that agreement. It is the Randing of all physicians in Ontario who are qualified to practise in Ontario or who are engaged in the practise of medicine in Ontario or who conduct health research. We now see a conflict between two organizations, or two unions, in relationship to whether the Rand formula should apply. My discussion is very much directly to the point of Bill 135.

1700

The second point I wanted to respond to, and to place a question to Mr Wessenger, relates to a response he gave earlier regarding the joint management committee which arose out of a question regarding whether bargaining was in good faith, and the question related to the funding of the joint management committee. Mr Wessenger responded that the Ontario Medical Association and the Ministry of Health would "fund their own costs." There is no indication of what commitment there is from the Ministry of Health or from the OMA in respect of the funding levels or the nature of the agreement between them.

If four of the five issues involve cost to the Ontario Medical Association, and item 4, which is to be discussed, is the portion of the joint management committee agenda that the government agrees to take on, does that mean the Ontario Medical Association will bear the entire cost of the agreement?

Mr Wessenger: What we mean by both sides paying their own expenses with respect to their representation on the board is that the representation on the board by the OMA will be paid however they deal with it and the same with the government side. The ministry will end up funding the special research staff with respect to the joint management committee. However, as far as what the budget is going to be is concerned, I think it was very well dealt with by Dr Wyman who indicated that the matter of the budget would be a matter worked out at the joint management committee.

Mrs Sullivan: In other words there is in fact no commitment in relation to specific funding for the joint management committee from the government?

Mr Wessenger: There will be a recommendation coming very shortly with respect to the matter of funding of the joint management committee. It is fair to say that it will be dealt with quite expeditiously.

The Chair: Thank you, Mrs Sullivan. Mr Wessenger, you have the floor.

Mr Wessenger: I would like to go back to first premises here. What we are dealing with is the legislation of the Rand formula, which basically says that members who benefit from the bargaining unit ought to pay fees. Certainly it is my opinion and the position of the government that all physicians benefit from the bargaining made by the OMA, because we have to remember we live in a market economy and the salaries physicians earn are related to the earnings physicians make on fees for service. We cannot really separate those two, so we should remember that. All physicians benefit from the bargaining by the OMA, whether they do it directly or indirectly.

With respect to the whole question of consultation, I would like to make a comment that the minister met with the Ontario Council of University Faculty Associations this summer with respect to this issue and others, and staff, in fact, were assigned to try to assist OCUFA and the OMA to work things out. Unfortunately, an agreement has not yet been worked out, but we do support, and both sides in fact have agreed to continue to try to work out an agreement with respect to this matter.

The Chair: Thank you, Mr Wessenger.

I am going to call the amendment now by Mr J. Wilson.

All those in favour of the amendment as placed by Mr Wilson, please so signify.

Those opposed?

Motion negatived.

Section 1 agreed to.

Sections 2 to 11, inclusive, agreed to.

Title agreed to.

Bill ordered to be reported.

The Chair: That concludes the committee's consideration of Bill 135. We have agreed to have a meeting of the subcommittee immediately following adjournment. That is just to inform all whips that they are expected to stay. It should not be a long meeting. There being no further business, the standing committee on social development now stands adjourned.

The committee adjourned at 1710.

CONTENTS

Tuesday 3 December 1991

Ontario Medical Association Dues Act, 1991, Bill 135	S-947
---	-------

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Chair: Caplan, Elinor (Oriole L)

Vice-Chair: Sola, John (Mississauga East L)

Fawcett, Joan M. (Northumberland L)

Haeck, Christel (St. Catharines-Brock NDP)

Hope, Randy R. (Chatham-Kent NDP)

Malkowski, Gary (York East NDP)

Martin, Tony (Sault Ste Marie NDP)

Owens, Stephen (Scarborough Centre NDP)

Sullivan, Barbara (Halton Centre L)

Wessenger, Paul (Simcoe Centre NDP)

Wilson, Jim (Simcoe West PC)

Witmer, Elizabeth (Waterloo North PC)

Substitution: Cunningham, Dianne (London North PC) for Mrs Witmer

Clerk: Mellor, Lynn

Staff: Spakowski, Mark, Legislative Counsel, Ministry of the Attorney General



S-39 1991

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Tuesday 17 December 1991

Journal des débats (Hansard)

Le mardi 17 décembre 1991

Standing committee on social development

Waste Management Act, 1991

Comité permanent des affaires sociales

Loi de 1991 sur la gestion
des déchets



Chair: Elinor Caplan
Clerk: Lynn Mellor

Présidente : Elinor Caplan
Greffière : Lynn Mellor

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Éditeur des débats : Don Cameron

Table of Contents

Table of Contents for proceedings reported in this issue appears at the back, together with a list of committee members and other members taking part.

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Table des matières

La table des matières des séances rapportées dans ce numéro se trouve à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et des autres députés ayant participé.

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au (416) 325-7400.

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 17 December 1991

The committee met at 1540 in committee room 1.

WASTE MANAGEMENT ACT, 1991

LOI DE 1991 SUR LA GESTION DES DÉCHETS

Consideration of Bill 143, An Act respecting the Management of Waste in the Greater Toronto Area and to amend the Environmental Protection Act / Projet de loi 143, Loi concernant la gestion des déchets dans la région du grand Toronto et modifiant la Loi sur la protection de l'environnement.

SUBCOMMITTEE REPORT

The Chair: Are we ready to proceed? I thought we really should try to get everybody here for this meeting, because it is the first meeting of the committee. We will be dealing with the report of the subcommittee. I hope we will agree on the kinds of procedural rules and so forth that we did the last time—everyone was clear as to how we would move forward in the future—and be able to have those debates and agreements today.

The clerk is submitting the budget, but I think we should begin with the report of the subcommittee.

All members have the report and the subcommittee has recommended two options. Is Mr Wiseman here? You are the whip and you were going to check to see whether option 1 or option 2 was acceptable to the government.

Mr Wiseman: Our preference is for option 1.

The Chair: Government preference is option 1. Are we willing to consider option 2?

Mr Wiseman: The difficulty arises at the other end with option 2. The week of March 9 is a very difficult week for us.

The Chair: I spoke directly to your whip, because that was the discussion at the committee. It is my understanding that the House leader's office—Mr Cooke has said there was some flexibility and willingness to permit sittings the week of the 9th and I spoke directly to your whip, Mrs Coppen, and she said she would also be flexible on the week of the 9th. I just report that to the committee, and if you have not spoken to them you might want to do so. I hoped this could be resolved in an amiable way and we could have a consensus. Is that possible, Mr Wiseman?

Mr Wiseman: Not at this time.

Mr Cousens: Madam Chairman, if we are able to have option 2, there are some benefits to it. One is that the extra time given to people to prepare their response is meaningful in that December is not a good month for preparation; we get back very early in January. The time to enrol and be accepted for presentations beginning in the week of January 13 really gives a very short period for them to prepare. I strongly support option 2 and that is the number one reason. I cannot speak for the official

opposition, but some compromise on how we handle the fifth week—and if it is not March 9 there might be another time we can do it so it might have to be abbreviated. There is a sense of willingness to try to work that through.

Mr McClelland: We will try to find whatever accommodation we can. I think Mr Cousens's points are well taken and there is no need repeating them. It is important that people be given an adequate opportunity to prepare. I should add that it is my understanding in discussion with our whip and House leader that there was, as you have stated, a willingness of the government leadership at the level of whip and House leader to have some flexibility and to consider it. I suppose that either has not been passed down or there is a difference of opinion between the whip of this committee and the other two individuals. That is fine. That can be sorted out, I am sure, in due course but I think the point is well taken.

The other thing that is very important is that option 2 affords the opportunity for the material presented before the committee to be considered over the course of a week or so. Option 1 precludes that, really. You are suggesting, in terms of option 1, that the committee, having travelled across the province and the bulk of the time being spent here in Toronto, comes back and has basically two days to review all the material, consolidate it and bring it to bear on the clause-by-clause deliberations. I think it is unreasonable to expect that. It is particularly unreasonable to expect it to happen on the heels of a week's travel.

One of the fundamental points in terms of the negotiations in the first instance when the government considered a time closure motion—it is important to note that the House leaders negotiated this and arrived at a compromise solution. One of the key ingredients from our caucus was that there be an opportunity to review the material; that there be a time between the final submissions and the beginning of clause-by-clause. Option 2 affords that opportunity.

As Mr Cousens has said, we are prepared to look at other times that may accommodate that, but clearly option 2 suits that and meets the legitimate need of people making major presentations. Bear in mind the people doing the presentation for an hour come the first week, a good number of them. They want to do justice to it and they want to prepare adequately. It really is—I do not want to use the word "unfair," but I think it is less than accommodating to not afford them that other week.

Mr Wiseman: I disagree with what Mr McClelland has just outlined. If we begin on January 14, 1992, we would have three weeks and then there would be a week off, February 3, which would return us on February 10 and then go to clause-by-clause on February 17. I think the week of February 3 affords us the opportunity to review at least 60% of the presentations at that point and would give us a very good sense and would allow us to carry, with our

short-term memories and long-term memories, into the clause-by-clause and have this finished by February 21.

The other alternative calls upon us to drag this out over eight weeks as opposed to six. In terms of what I have already made commitments to and so on, I think doing it in the most compact form would be the most advantageous to myself to achieve the goals of understanding this bill, doing the clause-by-clause and finishing this.

Mrs Witmer: I just heard Mr Wiseman say that to accommodate his schedule we should be proceeding with option 1. I always thought it was the function of a committee, if we are going to have public hearings, to make sure that those people making a presentation have every opportunity to prepare adequately, present the information and then for all committee members as well as staff to review the information and give due consideration to all the information whether it has been presented the first week or the fourth week. I wonder, if Mr Wiseman would want to do that, if there is any opportunity for him to change his schedule.

Mr Wiseman: I would be quite able to accommodate all the information that will be presented to us within the time frame that is there. I think the presenters will also have adequate time to do that. However, I do not think this is going to be solved at this level so I suggest that maybe we leave this in the hands of the whips and the chairs and live or die by what they agree to.

The Chair: The suggestion I have as committee Chair is that from my experience it is always better if a committee can reach the accommodation and establish both the tone and the consensus for working together at its very first meeting rather than passing that off. I have shared with the committee the discussion I had with the government chief whip and the understanding I had from her around the position of the House leader. Certainly, this committee can decide not to make a decision, and that in itself is a decision. We have a report we are dealing with. What is the wish of committee members; to deal with this today or leave it to the House leaders to determine the schedule for the committee?

Mr Cousens: I think we have agreed to disagree. I say option 2. I see Mr McClelland saying option 2. I hear Mr Wiseman saying option 1, so there is no agreement.

The Chair: We are then to just refer the matter to the House leaders? All right, it is the wish of the committee that item 1 of the subcommittee's report is referred to the House leaders for determination. Agreed? Agreed.

There are some additional parts of the subcommittee report that hopefully we can reach accommodation on. The first was the suggestion—actually it is contained in part 1, but I think it can be lifted out—as to when the minister and her staff would make their presentations before the committee. There was one option that had the minister making her presentation with her staff before the committee on the first day of public hearings. The other option was the one where the minister and her staff would be making a presentation at the committee on the first day of clause-by-clause. Can I ask the whips of the committee whether there has been any conclusion as to how to proceed?

1550

Mr Wiseman: Our preference, and it has been very strongly indicated to us by the minister, is that she would like to appear on the first day of hearings.

Mr McClelland: There is nothing wrong with doing things out of the ordinary. Certainly that has become customary of late, but our position remains that we want to maintain the standard that the time for the committee is for outside presenters. We are prepared to accommodate the minister at clause-by-clause, at either the beginning or conclusion of that.

The Chair: There is precedent for both within the committee. The clerk has informed me that when you are looking at parliamentary precedents, both occasions, both at the beginning of public hearings as well as the beginning of clause-by-clause, have been times used by ministers for those presentations.

Mr Cousens: I think the minister has had ample time to comment on Bill 143 in the House. She may well have a chance to reprise the presentations that come in. There will be a number of different things that we will have learned, and what may well happen if she takes her opportunity before we hear those is that she will not be able to help nurture our thinking following them. I think the time where she can have the greatest impact on all of us is after having listened to everyone else and just before we do the clause-by-clause. I think Mr McClelland makes a very good point.

Mr Martin: I wanted to make the comment that you had made, that it did not seem to me that this was so much out of the ordinary. If I remember correctly, when the Regulated Health Professions Act went through, the minister spoke to us before we took off on our journey and then we heard from the ministry afterwards. I think that in that instance the minister, for me personally anyway, set a tone that challenged us to be open to what we would hear across the province so that we might make recommendations and amendments to that legislation which reflected the fact that we had listened to the people and wanted to put in place the best piece of legislation we could put together as a committee. For me to serve on this committee, it would be in the best interest of the people of Ontario that I be given direction by the minister and the ministry at that point and perhaps even again after we come back and before we proceed with clause-by-clause. We might hear from her or her staff so that we might be as informed as absolutely possible in front of this really important question.

Mr Hope: To the members opposite who may be well familiarized with environmental issues, and for us who have not been strong activists in the environmental field, I think it is very important that the minister make presentations or opening statements to us to give us some kind of guidelines and direction on which way she sees the problem going. I know through other hearings that we have had the opportunity to readdress the minister on particular issues we have heard through the presentations that have been made to us, but I think for the setting of the stage, as we call it, and leading us into public hearings, it is most appropriate that the minister address those concerns.

Nothing against Mr Cousens or Mr McClelland. I know they are very knowledgeable about environmental issues. Some of us are more environmental in different areas, but I think it is very important for us as we reflect on the greater Toronto area, those who are not members of the greater Toronto area, that the direction and the vision the minister sees come before us before we start talking to the public so that we can do the comparison between the two.

Mr O'Connor: I think Mr McClelland and Mr Cousens raised a valid point. I think clause-by-clause is a good time for the minister to come to address us. I have to agree of course with my colleagues on this side. They raised a point on the matter of setting a tone. Maybe we can encourage the minister to come back and see us at clause-by-clause as well as at the beginning; that after we have heard some participation, as Mr McClelland has raised so eloquently, we should have the minister come back then just to hear some of what the input has been and speak to the committee again at that point in time. Perhaps he has hit a point that is worth taking note of: Invite the minister back on two occasions.

The Chair: There being no further speakers, we have the committee report, which recommends two options. I have heard a third. The first option is to have the minister on the first day of public hearings. The second is to have the minister on the first day of clause-by-clause. The third is to have the minister on both days. Shall we vote?

Mr Wiseman: What are we voting on exactly?

The Chair: We have the committee report which has the two options. You can vote on one of the two options in the committee report or the suggestion that has been made of a third option that has been put forward.

Mr Hope: You are asking for a vote on something. I think the committee has a determination through the process. If it feels it is important for the minister to return, I do not think we have to vote on that issue today. I feel it is very important that the minister come before the hearings. If during the hearing process the avenue is left open, I am sure we as a committee will have the ability to ask the minister to come forward again.

The Chair: I pointed out to the subcommittee, Mr Hope, that the minister or the parliamentary assistant sits in the chair, as you know from our previous work. As well, there are officials from the ministry here. What the committee was discussing was an invitation to the minister herself for an opportunity to address the committee and perhaps answer questions from committee members. It was the view of some that this would be most helpful at the start of public hearings. It was the view of others that it would be most helpful at the start of clause-by-clause. What we have to decide today, for the purposes of scheduling of public hearing time, is whether this committee is going to request that the minister make herself available and which of those times she is going to be requested to come to the committee.

Mr Hope: Let me be clear that what I am saying is that we choose between the two options: before or after. I am saying the option also has to be available to me, if during the hearing process I feel there is some controversy

between the statements that are being given and some of the issues—I am asking for the ability to have the minister readdress, but I am not laying it as option 1, 2 or 3. I firmly believe they ought to come to set the tone and which way we are going with the public hearings and to get a vision, but I am saying the ability, the avenue has to be also there for me as a member to ask for the minister to come back to have some questions or dialogue. I understand the parliamentary assistant is there through clause-by-clause, but I am asking for that pre-dialogue before we get into clause-by-clause.

The Chair: What I just heard, Mr Hope, is that you are speaking in favour of the third option, which is to ask the minister—

Mr Hope: That is not the third option. It is the first option with the ability—

The Chair: No, I am sorry. In the subcommittee report, option 1 was that the minister would make opening statements on the first day of public hearings. Option 2 was that the minister and staff would make opening statements on the first day of clause-by-clause consideration of the bill. Option 3 was put forward today, and that is that the minister not only make a statement on the first day of public hearings but also be available for the first day of clause-by-clause. In other words, the third option was both.

Mr Hope: Then you are reading me wrong.

Mr Wiseman: Can I try this?

The Chair: By all means.

1600

Mr Wiseman: We will try this one, see how it flies: that the minister and staff make opening statements on the first day of public hearings and before clause-by-clause or at any other time the committee deems it useful.

The Chair: The only consideration I point out to you is that, as I said, the minister at any time can assume the chair before the committee. The minister's representative, the parliamentary assistant, will stand in her stead and ministry staff will be here throughout the entire process. Members of committee can place in writing questions they want answered by the ministry as well, so there is always that opportunity. It is not like there is not going to be anyone here. The concern is the minister's schedule. This is to accommodate her so she will know when her appearance will be required before the committee.

That is the purpose of making the determination now, to help the minister in her scheduling. I do not believe it would be helpful to her for you to ask that she be on standby at the request of the committee at any time. As members of the government caucus, you can ask that and if she is available perhaps she will come and assume the chair and do that at a time when she is available. What we are trying to decide today is whether the committee as a whole would like to ensure that the minister has time in her schedule to appear before the committee either on the first day of public hearings or on the first day of clause-by-clause or both. It is as simple as that.

Mr McClelland: I do not know. You are very patient and I will try and take a lead from that. It seems to me that

we have been through this a number of times. Mr Wiseman and Mr Cousens and myself met under your leadership and we went through this a number of times. At the end of that, Mr Wiseman felt he had a particular position both with respect to the options and timing and indeed location. That may be resolved. We do not know. But it seems we are ending right back where we started. We were unable to find any accommodation at that point and we have come back here today.

There is still no consensus. We have deferred one matter to the House leaders and whips because there seems to be a difference of opinion with respect to what is available from the government side. It seems to me we are going there again. Maybe that is where the whole thing is going to have to rest.

The Chair: It seems to me that this is not an issue that can be decided or should be decided by the House leaders and would have to be decided by the committee.

Mr Martin: I hope I am not hearing from Mr McClelland by his comment about your patience—and certainly you are a patient person and have been, in my experience, over the last number of months, having sat on committee with you. If he is suggesting we should not have this discussion then I do not think he understands the process we are into here of trying to come to some common understanding.

Mr McClelland: No, that is not what I said.

The Chair: You do not have the floor, Mr McClelland. I will put you on the list.

Mr Martin: Actually, I am enjoying this discussion and I think it is really important that we have it so that we can agree on something. When I suggested a little earlier that the minister come perhaps at the beginning and then again before clause-by-clause, I was still working that out in my mind. We have had some discussion across the floor and I think it makes a lot of sense that she be here at the beginning, as I said before, to set the tone. If there is anybody close to this issue who has looked at it from every angle it is certainly she and her staff. I would like to hear that perspective, the things she and her staff see as important for us to be paying attention to as we travel around or as we sit here and listen to the various inputs we get.

I am suggesting, though, that perhaps we might alert her to the fact that we may in fact require her at the beginning of clause-by-clause. She could, I suppose, look at her schedule accordingly and make it possible for that to happen. In an environment of trying to get the best information we can and to be consultative and hear from the minister and have her involved as much as possible in the resolution of some of these issues, maybe it would be appropriate that she be told from time to time we may need to have her here.

I understand and know what you are saying about the fact that she can be here to replace the parliamentary assistant whenever. But we are saying a little bit more strongly because I certainly see this piece of legislation is an important element of our activity as a government. In fact, we would like to think she would be ready to come and speak to us at such time as we felt it was necessary. Our whip has

put it fairly simply—another option. I would be prepared to vote on that.

The Chair: I have the list of speakers: Mrs Witmer, Mr Hope, Mr McClelland, but I point out to you, Mr Martin, that the minister could choose, if she wishes, to carry this legislation herself. She does not have to have a parliamentary assistant in her stead. You can, as a member of the government caucus, discuss the matter with her if you wish as well.

Mrs Witmer: I regret that I am going to have to leave. We have another meeting. However, I would just like to remind the people present that I was present when the subcommittee met the first day, and there was Mr Wiseman and Mr McClelland and myself. At that time, Mr Wiseman put forward a proposal and I thought there was going to be communication, compromise and consultation. However, what I see today is the same proposal. I am really concerned about that.

There does not seem to be much attempt being made at compromise. I suggest it go back to the House leaders, because it is almost impossible to end up at a position that everybody is really quite happy with.

The Chair: The only thing we can reasonably ask the House leaders to do is what we have done, which is to set the time frame for the committee meetings, the actual schedule. The time the minister is to be requested to appear before the committee I believe is a decision that should be made by the committee. I will call the question now if you would like to—

Mr Cousens: Can I move recess of the committee meeting until we can have a caucus meeting?

The Chair: You would like to recess for how long?

Mr Cousens: Until 5 o'clock.

The Chair: I have had a request for a recess until 5 o'clock to accommodate a meeting. I think that is a reasonable request. The committee will reconvene at 5 o'clock.

The committee recessed at 1607.

1721

The Chair: We are considering the subcommittee report. Mr Wiseman, did you want to let the committee know what agreement, if any, has been reached?

Mr Wiseman: I think we have come close on the question of sitting time in the sense that—

The Chair: On the calendar?

Mr Wiseman: Yes. This would take unanimous consent and it would also take the consent of the House leaders to do this.

The Chair: What is your proposal?

Mr Wiseman: That would be that the committee would begin sitting on the 20th, follow the schedule to the 17th and that clause-by-clause could occur when the House resumes sitting in March. However, as the resolution stands, I think it would take the unanimous consent of the three party leaders to change this clause that says this committee will report on the first sitting day of the House.

Clerk of the Committee: If the committee can agree on 1, 2, 3, 4 of option 2 and they are looking for the first

week back—from the subcommittee meeting, I sent the letter. Are you looking at March 9 as the first week back?

Mr Wiseman: No. We are looking at the 23rd as the first week back.

Clerk of the Committee: Okay, because the request went in with March 9 with two options to the House leaders if the House was sitting or if the House was not sitting. So what I could do is revise that memo that went to them and say that the committee has agreed on this part of option 2 and change the request regarding March 9 I gave, and put that to the House leaders.

The Chair: If there was unanimous agreement at this committee that this be the recommendation to the House leaders and request that the time allocation motion be adjusted to permit clause-by-clause during the first week back, I think that would be a reasonable request.

Clerk of the Committee: That is looking at authorization to sit how many days of the week? This committee could sit two days a week, Mondays and Tuesdays.

Mr Wiseman: I do not know how that would be worked out, because we did not—

The Chair: The way it would work is that there would be a request of the House leaders to permit the committee to sit four days during the first week back, which would be the week of March 23, or to have three or four days for clause-by-clause debate. Perhaps to allow some flexibility, if the committee were to say unanimously that it would agree to either three or four sitting days at the discretion of the House leaders, that might—

Mr Wiseman: I think all of this is going to be at the discretion of the House leaders. It is just a suggestion of how to get past this—

The Chair: What we are looking for is a recommendation from this committee that we could say has unanimous agreement.

Mr McClelland: It seems to me that would be reasonable. I think the operative word in your own words was "permit." I think we could frame it in such a way as three or four days subject to the agreement of the House leaders and leave it with them to find the range of dates available. It is simply a matter of the amendment of a motion, which of course requires unanimous consent. That would be agreeable to all and I think it leaves it open with a range. I think our objective is to do justice to clause-by-clause. However that is achieved and whatever time frame accommodates all members is suitable to myself and I would hope to all members of this committee. That is the objective we are, hopefully, all looking towards attaining.

The Chair: To synthesize, unless anyone wants to speak to this, the proposal that the committee is now going to consider is a modification of option 2, and that is that the committee will meet for public hearings the weeks of January 20, January 27 and February 10. We will sit Mondays from 2 to 5 pm, Tuesdays, Wednesdays and Thursdays from 10 am to 12:30 pm and 2 pm to 5 pm, and that the committee will travel the week of February 17. That is agreed?

When it comes to consideration of clause-by-clause, the committee unanimously requests that the House leaders permit the standing committee on social development to have clause-by-clause consideration of the bill when the House resumes and that the House leaders would allocate three or four days, as they see fit, for clause-by-clause consideration of Bill 143.

Clerk of the Committee: The original request took into consideration that if there was a speech from the throne it would be three days. If there was not, it would be four days.

The Chair: The reason we are mentioning the three days would be because of the consideration that we would not be able to sit on the day there was a throne speech. The committee feels it could complete its business of clause-by-clause in three days and that this would stay within the spirit of the time allocation motion.

Do I have that correct? Can I then just ask for all in favour? Any opposed? That is agreed unanimously by the standing committee on social development.

That is item 1 and that has to do with the calendar and it will be up to the House leaders to decide whether the committee's request is acceptable to them.

The second item we have to decide on is the one we were discussing when the committee recessed for an hour, that is, when we want to invite the minister to attend before the committee. Has there been any consensus or agreement among the whips?

Mr McClelland: My feeling is that whatever accommodates the committee and the minister. We will leave it to her discretion, whether it be at the beginning of committee or clause-by-clause.

Mr Wiseman: The minister has made it very clear that she would like to be invited at the beginning of the hearings and at the beginning of clause-by-clause.

The Chair: What I have heard is that the committee will accommodate the minister's schedule and that she is welcome to attend at the committee at her pleasure, discretion and time availability. Agreed?

Mr Wiseman: Her time available or our time?

The Chair: Hers. We have said that we will respect her scheduling, and whenever she would like to attend the committee will accommodate that. That would be January 20, which is the first day. For scheduling, as far as witnesses, do you know how much time the minister said she would like? I think you had said she wants the full morning.

Mr O'Connor: I think we are only sitting from 2 until 5 on the first day.

The Chair: We are sitting on Monday, January 20. Monday would be 2 until 5.

Mr Cousens: It is a long time. I think the clerk could well work out an arrangement. If the minister is able to go till coffee break or something like that, there might be a chance to get a few presentations in that day. Who knows?

The Chair: Could we request that the clerk discuss with the minister's office the minister's time availability, how much time the minister will require that afternoon and

that if there is time to schedule additional representations on that day the clerk do so? Agreed? Agreed.

On March 23, if the minister wishes to attend what I have heard is that the committee certainly is willing to have the minister attend at her convenience. Agreed? Agreed.

Item 2, formally, on the subcommittee report.

1730

Mr Hope: I do not agree with the subcommittee report. What I would recommend is that groups, individuals or institutions have the ability to make a 40-minute presentation and individuals have the opportunity make a 20-minute presentation, which allows the clerk the ability to govern the schedules accordingly instead of trying to pick or choose what is going to happen.

The Chair: There was general agreement at the subcommittee. Perhaps if I could be helpful, I will tell you—all members are here who were there—what the discussion was and then they can speak to it. You certainly can jump in if I do not accurately portray the discussion.

Each of the caucuses felt there might be certain groups that would have more to say because of the nature of their interest in the legislation. It was agreed that each caucus would submit a list of who they felt should be invited to come to the committee and have one hour, in total, for both presentation as well as questions from the committee. They wanted to allow for additional time so that the committee members would be able to ask their questions.

Mr Hope: Could I ask what you just said? You said an hour for a presentation and an hour for questioning?

The Chair: No, an hour in total for both questions as well as presentation. The committee would identify those groups by list. The clerk has received those lists from all three caucuses. We then would advertise, as we always do. There would be other groups and so forth that would be requesting time. All others would be entitled to a total, for both presentation as well as questions, of 20 minutes.

As well, the committee had said it would consider, on the very first day, which would be January 20, not January 14, empowering the subcommittee to make the determination, if there were more groups that made a request to appear before the committee than there were time slots available, as to who would appear before the committee.

Is that an accurate portrayal of the discussion?

Mr Wiseman: I think that was a fairly accurate portrayal of the discussion. I believe I mentioned at that time as well about what we do if later on we find that we have not scheduled people for an appropriate amount of time or we have people who would like to speak longer. I think this is the crux of the issue as it arises now. I am going to let the debate continue because I have made my points and I think the committee should hear what the others have to say.

Mr Cousens: I am satisfied there was a consensus at that meeting in which each of the caucuses in submitting the names or suggestions for the one hour would have up to five. I know I started off with an extended list. It would have monopolized the entire four weeks and longer, but the clerk reminded me that you had five for one hour so

we gave a couple of supplementary names to assist her in finding five that would work. We accepted the fact that we would have five for one hour each and that all those others, although I still have a nice list, would be eligible for 20 minutes.

I am satisfied that if we can do that, others who would come in, whether a group or an individual, will get 20 minutes unless there is some consensus that is gained at some particular time during the meeting, which I think you alluded to, but five is my understanding of what Mr Wiseman and Mr McClelland also agreed to.

The Chair: There was an agreement that the subcommittee could meet and that there might be opportunity to add some additional time by extending the hours as appropriate.

Mr McClelland: Mr Hope, I understand where you are coming from and I want to say that at the outset. What happened was this, if I could, for the benefit of all: As Mr Cousens said, there was any number of organizations and people that each caucus felt would be appropriate to be invited. We went through a considerable discussion and we felt we had an accommodation. By way of example, I thought the appropriate time breakdown would be an hour and then a half-hour, but when we arrived at accommodation, it is an hour and then 20 minutes. I still want, and I am not going to get it, a half-hour for other people to come, but we agreed to that and said, "Okay, we'll prepare a list and submit it for that one hour."

I would like to draw to your attention as well, Mr Hope, that what happened, in the context of that discussion where we had an agreement, was that I came with a list of 29 or 30 groups, organizations and individuals, and we pared it down to five priority invitees to have that one hour. We went through that process, and I will tell you we spent considerable time and made some difficult decisions in terms of who those individuals should be.

It is important that you understand it was done in the context of what was, I think, generally accepted to be an agreement of all three parties. We also said we would establish that as the general framework within which we would operate, because it was necessary, and it was the Chair who suggested it was important that we establish a framework so we knew what the ground rules were and there was no sense of anxiety or difficulty throughout the course of this hearing process. It may be difficult enough in and of itself, so we established that.

Having established that, there was always the room, with unanimity, to change, but the essential ingredient was that we would establish the framework and go by that unless there was an all-party agreement to change it so we had a sense of knowing where we were going and so we did not get into procedural wrangling. It is very important for the turnout of the committee throughout the course of the hearings.

I want to point it in that framework, because I think it is important that you understand, recognizing where you are coming from, the context in which this solution, if you will, to accommodate as best as we could all three parties was arrived at. It was not done easily. It was done with

some give and take and a fair bit of discussion and, as I say, an accommodation by all people, as far as I can recall.

Mr O'Connor: Maybe I am missing something in the translation, but when we talk about presentations on the per-hour basis we are talking about a balanced presentation, those who are in favour and those who oppose it, which seems to give a little flexibility to the clerk's office. She usually does provide within reason.

My concern is that by limiting it to an hour just for the one week alone there are perhaps going to be groups that come forward, and we have not got where we are travelling yet. There are perhaps going to be representatives of some councils that would like to make a presentation. Limiting them right off the bat to 20 minutes, I do not think is fair. My sense would be that if we allowed 20 minutes for individuals, larger groups—institutions, organizations and perhaps municipal councillors or whatever, people who represent a few more people than just perhaps an interest they have themselves—be allowed double that, 40 minutes. I think that will allow for a little more balance.

Of course, we depend on the clerk's office to put in that certain amount of balance. The clerk's office tries to balance things in making sure there is equal representation, people who are opposed and for. In the committee hearings I have been through so far there seems to have been a very good balance in that way. Whether that has been a negotiated balance, I am not sure, because I was not on the subcommittee in that hearing. But it seemed there was a pretty good balance.

I think we have to be flexible, because if we start putting it in concrete and stone right now, then it is not going to work as far as being as open as we can during the process is concerned.

1740

The Chair: Perhaps just to be helpful, in the previous experience of the standing committee on social development when we were dealing with the Regulated Health Professions Act, the decision at that time was that groups and organizations would have 20 minutes for their presentation and individuals would have 10 minutes. That was the experience of the committee. Mr Hope, Ms Haeck and Mr Martin were all on the committee, and I think the experience of the committee was that while that was a very tight time frame, it was a reasonable time frame that also allowed for the kind of discussion and questioning and so on.

Given the nature of this bill, there was a discussion at the subcommittee, and it was felt that there were some interests and organizations and groups that might require even more time than the 20 minutes which had been the time for the large groups which came before the committee earlier.

The suggestion was, as Mr Cousens said, that each of the caucuses would identify five or six they would like to invite to come for one hour so that there would be plenty of time for questioning by committee members. It was then discussed how much time for all of the others, municipalities and individuals, and because of the experience the committee had before, 20 minutes was seen as quite generous, because that had been the maximum amount of time.

The subcommittee, I believe, wanted to accommodate as many people as possible to appear before the committee.

On the issue you have raised around balance, the subcommittee made the decision in its report that requests would be received on a first-come, first-served basis and that any that could not be accommodated within the time established would be considered by the subcommittee, and that the subcommittee would make those decisions.

It was also understood that the one-hour appointments would be booked for the first week, as the cutoff date—which I am going to recommend some flexibility on to allow us to ensure that all of the available time is made available to those who want to appear before the committee—is as late as possible because of the time of the year and how difficult it is for people; sometimes they have missed the first ad, that sort of thing, because of Christmas. It was a little complicated, but I know the subcommittee members spent a good deal of time.

No direction was given to the clerk or to the subcommittee around who was coming in on which side. You should be aware of that. The clerk would require very specific direction. I would also point out that the last time this committee met, I do not believe the clerk attempted to balance presentations, but the committee decided then, as it did now, that anyone who wanted to be heard would be heard on a first-come, first-served basis, given the time that was made available for presentations. As we were only booking until 5 o'clock, then the time from 5 to 6 was available if the subcommittee felt there were representations that should be heard before the committee; it would be the subcommittee, not the clerk, that would make those decisions.

That is just to give you all the information. Is that correct and accurate, Mr Wiseman?

Mr Wiseman: I think the way you have just described it does contain a lot of flexibility. What Mr McClelland included in terms of this committee being able to make alterations to the timetable on unanimous consent is also something that bears keeping in mind. I think that is a fairly accurate portrayal—"fairly" in the fair sense as opposed to in the "close to" sense.

The Chair: I appreciate the definitional difference, and I think it is important. I tried to be not only fair but also accurate in the portrayal of what happened. I am trying to be helpful to all members, as I attend the subcommittee meetings; sometimes if I am able to describe, and everyone agrees that is the way it was, it will save some debate at the committee.

Mr Hope: If I start agreeing with you too much I get a little scared.

The Chair: Mr Hope, what did you say?

Mr Hope: I do not ever believe in rubber-stamping situations. That is why I am expressing my point of view here, and it may be different from what the others here think. I understand what you are trying to get at as far as the hour and the five groups. There may be experts outside of the greater Toronto area who will have to travel to this committee to be here. One of my concerns was that there

might be groups outside of the Toronto area who may be the allocated hour experts.

The Chair: There is nothing to restrict the one-hour appointments to Toronto only.

Mr Hope: It says the first week. That is what you told me.

The Chair: No, what we said was that the clerk would book the first week. However, if your caucus in submitting the five or six names has a group it would like to be heard in a place we are travelling to, that request could be made and the clerk could book that accordingly. The reason for the clerk booking most of the one-hour appointments in that first week in Toronto was because of the advertising and the cutoff date being after that, and that was for all the 20-minute appointments to take place.

Mr Hope: That is why I was listening to what you were saying, and what you were saying was—

The Chair: No, you could if you wish make a request from your list of five or six to be—the subcommittee as well can make whatever change or determination it wishes in the future.

Mr Hope: Now you are clear.

The Chair: I want to be clear.

Mr Hope: But your first comments reflected the first week of the hearings to be the hour long. I am sitting here looking at a schedule; you have somebody going halfway through a presentation and then you would have to cut him off, we would go for lunch and come back and they would finish the half-hour, because you have two and a half hours in the morning. I understand what you are saying now, and you are clear.

I do not know where the experts are, and there are a number of experts in the field. All I am thinking is that it puts an equal balance in the system, and that is what I am trying to do. If the others disagree with me, fine. It will go to a vote. I always expected that.

Mr McClelland: I am trying to be helpful. I think there will be a balance, to an extent; there will never be a perfect balance. There is some flexibility built into it. I am glad that point was clarified. The purpose of the hour in the first week was simply that it is an identified group, but the other is a yet-to-be-determined group of those people who would respond to advertising. It follows logically that they would be fit in at a later date; they may well want to come the first day if they respond quickly. I think that has been cleared up now. It is just a matter of accommodating to facilitate the organization of the clerk.

Mr Wiseman and Mr Cousins and I had a discussion. There very well may be groups or individuals we all want to hear from; there may not be, to be candid, but there may be. I do not know; I just do not know who is going come forward on this. I think the flexibility remains to accommodate them for an hour. If we agree we might even want to extend it and ask them back again or stay on a little later or start early, whatever—that remains. As I said, it was with a view to trying to establish some frame of reference and then we know where we are going, for the most part.

Ms Haeck: Just to hark back to our wonderful Regulated Health Professions Act days, in travelling to the four centres that we did visit, we definitely adjusted our schedule to meet the demand. I think the clerk will recognize that as well, that some centres were definitely quite burgeoning, shall we say—that is not the best way of putting it, but burgeoning with a lot of folks out there. We were working from 9 until noon and then starting sometime right at 1 again and trying to accommodate the concerns that were being raised by those groups.

The Chair: That was discussed after the subcommittee. Again, based on the experience we had had before, it was understood—although I think we can amend the report if you wish—that we would be as accommodating as we could, but that those decisions would be made by the clerk based on flight times as well as by the subcommittee if an issue came up that would require some adjustment.

Ms Haeck: I think it is worth while if these issues raised here are clarified. I must admit that in my late arrival this afternoon and in looking at the printed page and having some of these discussions, how you have fleshed it out has made sure that my own concern that some people might in fact not be accommodated has been satisfied to a very large degree.

1750

The Chair: Item 4 says: "That the committee will travel Sunday evening to the first location and each evening after that day's meeting to the next location, ensuring flexibility due to possible weather problems. The time for meetings out of town would be 10 am to 12:30 pm and 1:30 pm to 4:30 pm as required, taking into consideration the number of deputations requested and the travel arrangements."

I think that is as specific as we can be until we know what kinds of requests come in. I point out that in this report the subcommittee is empowered to make adjustments and changes.

Mr Wiseman: This is the question that came up in the subcommittee meeting and here it is again. In the first week we allocated the hours and now, in response to I think it was Christel, you said we did not have to keep all the hours in the first week.

The Chair: No, I did not say that. What I said to Mr Hope was that each of the caucuses had agreed to submit a list of five or six to which it would like to have allocated one hour in total. The understanding was that the clerk would schedule those from that list during the first week unless there was a specific request that a group be heard out of town, in which case the one hour would be allocated at the out-of-town meeting. For example, if you had a group that was based in Sarnia, the clerk would schedule it and give it its one hour in Sarnia, if that is what it wanted.

Mr Wiseman: I hate to throw this monkey wrench at you, but if the groups that are in Sarnia and Kingston, the two locations we have agreed on, are not on the list now, then what we have done effectively is say they get 20 minutes. Is that right?

The Chair: What will happen is that the subcommittee could determine, based on availability and time and agreement, to alter, because you are empowering the subcommittee to make those decisions.

Mr Wiseman: Okay. That is more flexibility than I thought was in the original agreement. That is fine.

The Chair: Satisfied?

Mr Wiseman: Absolutely.

The Chair: Do we have to vote? Is there agreement? It is all in Hansard. Everybody has said it has been fairly clear.

Mr Hope: I would just like to register that I am not in support of that.

The Chair: You want to vote? Is that what you are saying?

Mr Hope: No, I am just saying that if you do not want to, I want you to know that I do not agree with that.

The Chair: No, we are happy to vote and allow you to express yourself on the record. If you want a recorded vote, that is fine.

All those in favour of the committee report? That is item 2 with the amendment that says, "Any additional requests for one-hour appointments would be determined by the subcommittee based on time availability."

Mr Wiseman: Then obviously if no agreement was made there, it could come to the full committee. That is always understood.

The Chair: Of course, always. All in favour?

Agreed to.

The Chair: Mr Hope, you are opposed?

Mr Hope: Opposed.

The Chair: Hansard will note that.

Interjection.

The Chair: Yes, good. I am really glad you pointed that out. Those of us who served with Mr Hope over the course of the other hearings are very aware of what a fine member of the committee he is.

Mr Cousens: You know what it is like to be in opposition now.

The Chair: There is another matter contained in item 2 which has to do with the cutoff date. January 13 has been suggested as the cutoff date. That will be mentioned in the letters and the advertisements and so forth. I would like to recommend that we not be quite that rigid in saying only that this is the date, but that the subcommittee be empowered to consider any requests that come in after January 13 and, based on time availability, be permitted to schedule them. Agreed? Yes. Agreed.

Ms Haeck: Could I ask one question? Has the clerk, in the short time this has been open for discussion, had a sense of the volume of requests we are going to get?

Clerk of the Committee: No, I have no idea. I know how many submissions. I have not counted them, but I know how long the list is in total of the submissions by the three caucuses for the one-hour appointments and for the other letters of invitation going out. Basically what it boils

down to is a letter of notification. I have no idea what the responses might be. Often you will send out letters. Some people will respond positively, some will respond negatively and some will not respond at all.

Ms Haeck: I was just curious, because knowing the volume received in our other hearings, having the deadline, at least you had some wherewithal of scheduling. Leaving things to the last minute gives me some concern.

The Chair: It will be helpful. Given the 13th, it will not be as difficult as we had first thought. If we begin on January 20, there will be some time for scheduling during that first week. As well, the first week will be taken up with the up to 18 now. I want to be clear when Hansard is recording. The expectation is there will be no more than six requests from each caucus for one-hour appointments unless that is approved by the subcommittee. That is agreed.

Mr Hope: No more than five is what we said.

The Chair: We said five or six maximum. That was the number.

Clerk of the Committee: We have a bigger list.

The Chair: We have a lot, right, but everybody else would be—

Clerk of the Committee: It will depend on the response.

The Chair: On the cutoff date, is there agreement and consent of the committee that the cutoff of the 13th be flexible inasmuch as the steering committee can consider any late requests and determine, based on time availability, if we can hear others that have requested to appear before the committee? The reason for this is that this is a very difficult time of year. People may have missed the notification. In a minute I am going to be giving you some information on the advertising.

Mr Cousens: Agreed. Do not tell us again.

The Chair: All those in favour? Any opposed? Mr Hope? That is unanimous.

Item 3, the final copy: The difficulty we had with this one was that we believed the out-of-town ads should be placed as close to the December 19 date as possible. Due to the time of the year, just before Christmas, the concern is that some people may miss that ad. The suggestion is that we place an additional ad on January 6, indicating the date of the meeting at the location and repeating the message.

Clerk of the Committee: Just for the out-of-town.

The Chair: This is just for the out-of-town locations, to readvertise on the 6th with the exact date and the location of those meetings. Agreed? Discussion?

Mr Hope: What would the radius of the advertisement be? For instance, I am using Sarnia. What would the radius of mileage from Sarnia be?

The Chair: It would be the local daily newspaper in Sarnia.

Mr Hope: So if a person living in Chatham does not receive the Sarnia paper, then he is out of luck?

The Chair: You would have to tell him. As with any travelling committee, the practice is that the advertising takes place in that community, and if you feel others have an interest, you can let them know. Members, as you know, have the opportunity to do that.

Mr Wiseman: I just think that since the Toronto dailies are distributed throughout southern Ontario, and that ad is going in, I wonder if it might not be possible to include in that ad that we will be in Sarnia, Kingston and wherever.

The Chair: The problem is that the copy was approved and had to be out yesterday for the deadline. Because the committee had not decided on the out-of-town locations, that was not possible.

Mr Wiseman: That far ahead?

The Chair: Yes, that far. If the committee decides, you could put an additional ad in the Toronto dailies in the first week of January.

Mr Wiseman: It would be awfully expensive to run a separate ad.

The Chair: We do not have that in the budget.

Clerk of the Committee: We could do that as well.

The Chair: We could do that as well and actually include that, rerun the ad, given the time of the year, if you wish.

1800

Mr Hope: One of my concerns is local paper versus distribution. I know you are trying to be cost-efficient in this matter, but for Sarnia, for instance, the local paper may be the London Free Press, more so than the daily Sarnia Observer or whatever it is called. What I am looking for is a wide range of advertisement. It is not my responsibility, it is the government's responsibility to make sure that the advertising for public hearings is out there and open and accessible to people. Not everybody purchases a certain paper. That is why I raised the question. Everybody who is an environmentalist would care about this.

Mr O'Connor: Just as a suggestion that may help facilitate Mr Hope's concern, in the communities we travel to that have daily papers—in the small communities I represent there is no daily newspaper. In the case of most communities, where the community newspaper comes out weekly, an ad in a weekly paper prior to our visit, rather than trying to put an ad in the dailies, would probably save an awful lot of money. It would not be cheaper than the dailies? That is incredible.

The Chair: The practice of committee, as far as advertising is concerned, is that we advertise in the major dailies in Toronto. If possible, we list the locations where we are going to be outside of Toronto. It was not possible to do that in time for the deadline. If the committee wishes, we can advertise again in the Toronto dailies. We also then, as a practice, advertise in the daily newspapers in the communities where we are going.

Further to that, I have found one of the things that some of the members have done—can I just finish?

Mr Hope: If I may interrupt you, to save you a lot of time—

The Chair: Yes.

Mr Hope: I just raised some concerns. I know it is standard practice. Can we just move on and the advertisement will go as scheduled? I have particular concerns when it is outside Toronto. I have it on Hansard and I think we can look on.

The Chair: No, I think there are opportunities—

Mr Hope: I look at the clock and it is 6:05.

The Chair: Okay. There are opportunities as well. I know many of the local small community papers will run community news. If members will just notify those newspapers of what is going, that may help to satisfy your concern, Mr Hope. I know that is a vehicle many of the small community newspapers will do as a courtesy to members.

All in favour of the committee report? Have we agreed to advertise a second time on January 6 for the out-of-town locations, and do we want to advertise the dates of the out-of-town committees as well a second time in the Toronto dailies on January 6? The recommendation is that on January 6 we advertise a second time, both in the Toronto dailies and in the local communities where we are going to be visiting. All in favour? Any opposed? That is carried.

We have already agreed to item 4.

Item 5 is locations. Have we got consensus on locations, Mr Wiseman, from the whips?

Mr Wiseman: We have Kingston and Sarnia and we like Sudbury. I will leave it to Mr Martin to explain.

Mr Martin: We would prefer not to go to Kirkland Lake. We think that will focus the discussion too narrowly. We also have a situation where we really have a conflict of interest there. We think that Sudbury, being more central to the north, could speak more adequately for the whole of the north, how we view the waste problem in the greater Toronto area. However, not agreeing on Sudbury, certainly there are some other locations that I think would be more appropriate, as far as we from the north are concerned, than Kirkland Lake, such as, perhaps, Kapuskasing or even Ignace.

Mrs Fawcett: Could you explain what you mean by the conflict of interest for Kirkland Lake? I know what you are talking about, but why is it a conflict of interest?

Mr Martin: Certainly Kirkland Lake has presented a proposal in the past to deal with the garbage issue re the greater Toronto area and has an economic interest in having that proposal be part of the larger package, and I think going there will focus the discussion solely on that issue. In my mind, that constitutes a conflict of interest. You are not getting a broader look at the question re the perspective on this issue of those of us who live and work in the north. You are getting a very focused view of it from there, and to my mind it would not be an appropriate place to go.

Mrs Fawcett: Why do you feel everything is going to be focused in one particular area there from Kirkland Lake? There could quite well be other sides of the story

come forward. Certainly we would get that side of the issue. It is not the only thing we are going to hear.

Mr Martin: I am suggesting that by going to a more central location you will certainly get that and that anybody who would travel to Kirkland Lake would certainly have no difficulty getting to Sudbury to make a presentation.

Mr Cousens: In presenting the suggestion for Kirkland Lake, I was somewhat sympathetic and did a certain amount of moving around. The government member, Mr Wiseman, was looking for Sarnia, I understood, in the first meeting, so I went along with Sarnia. I understood that someone was pushing for—anyway, I agreed with the other two and I thought Kirkland Lake would be interesting for a number of reasons, such as the significance of it to Metro Toronto and the works department, the studies that have been put into it. The municipality has recently had a referendum on the issue of whether an environmental assessment is something that should be considered, so the community is aware of it. I think you are talking about a community that has had a lot of discussion around the subject. So as a committee we can come as well and look at the site.

That may be a conflict of interest for someone, but I have not seen the Adams site and I view it as an important opportunity while on this committee to at least look at the site and, although I am not an environmentalist who has any scientific credentials, understand why this site has been ruled out. We will have a chance to hear the views of those who are involved and part of it. The Adams site visit would be well worth while to me.

I am interested in seeing something of the rail linkages as well, because we know something about rail services coming through from the Toronto area in which you change engines in North Bay and then they take the same train on up to Kirkland Lake. There would be a sense of just seeing, "Hey, it's there." I would like to see it, whether or not it is as I have heard it to be. Seeing is believing in that sense.

As well, an awful lot of my time as critic for Bill 143 has been spent criticizing the Minister of the Environment's position that has opposed having a site chosen for landfill outside the boundaries of the greater Toronto area. The fact that this has been one of those places that has been selected and considered—I forget the number of dollars; is it \$40 million? A large number of dollars has been invested already in assessing that site. Inasmuch as it is a very important part of my concerns and my party's concerns about Bill 143, it has to do with the minister's prerogative to have a policy decision on the shipping of waste outside Metro, specifically limiting the option of Kirkland Lake, that makes Kirkland Lake a very important part of the visits.

I am prepared, as the critic from our party, or the whip or whatever I am from our caucus—I move from position to position—

Mr Hope: You are so flexible.

1810

Mr Cousens: I am very flexible. But I only put forward one place for the four days we would be visiting, and

that was Kirkland Lake. I am prepared to be accommodated on other areas. I have very great difficulty in seeing Kirkland Lake ruled out of order, for the reasons I have just given.

The Chair: I have Mr McClelland and Mr O'Connor. Perhaps it would be helpful if we could get agreement on what we agree on and then debate that which we do not agree on. That might be a way of proceeding. Maybe we could decide we are going definitely to Kingston and Sarnia—is that possible—and then start to look at how many sites? No, you do not want to do it that way? Okay. You have the floor, Mr McClelland.

Mr McClelland: In response to your question, I think the point is it is difficult. Mr Cousens made his point. His last point was that he was prepared to accommodate all three other choices to obtain his one request. I think it is entirely unfair to Mr Cousens to say we will agree to all three and maintain discussion on—

Interjection.

The Chair: That would be helpful. You have the floor. You can speak.

Mr McClelland: I appreciate what you are saying. I just wanted to comment. Mr Martin is occupied at the present time, but it seems to me that the issue of financial investment—potential loss, potential gain—could and probably will be attached to any number of people in organizations and companies that may present to the committee. It is inevitable that we will run into organizations and companies that will be impacted financially, so I say respectfully that I do not find the argument about Kirkland Lake having a potential financial conflict compelling in any sense inasmuch as any number of organizations or groups may make money, lose money or have no financial investment of any kind. I just quite frankly do not find that argument compelling in any sense.

I come back to what we talked about earlier. We talked about this throughout. It seems to be a common thread that there has been accommodation on government requests for location of travel, with a simple request that one place out of the four be given to opposition parties. I do not find that extremely unreasonable.

Mr Cousens stated it very well. He is prepared to give up all three other locations for the one he thinks is important. I will not repeat what he said. I think he said it well. There are reasons to go there. I understand why the government does not want to go there. We all understand that, but I think it is in the sense of being reasonable and a bit of give and take. He has given up three for one.

Mr O'Connor: I have listened to some of the arguments. I suppose I cannot agree 100% on what I have heard from both sides. I think there has to be an element of fairness is this and there has to be some discussion among us, and come up with some sort of solution.

One thing that worries me in travelling to the north—and we talk to our constituents we represent down here—is the fact that Ignace was mentioned, Kapuskasing was mentioned, as well as Kirkland Lake, and we should try to accommodate them as well. There needs to be some way we can include them. I do not want to add any more days

to our travelling in the north, and I know travelling up there could be difficult at that time of year anyway. I think perhaps what Mr Martin was headed towards was maybe mentioning—I think he mentioned Sudbury as an alternative because of the travelling. Perhaps it might have been easier for people from Ignace and Kapuskasing to make it to Sudbury rather than Kirkland Lake and it might even facilitate the committee's travel a little bit.

Not totally disagreeing with what our opposition members have said, then maybe we should take a look at including—I will just throw this out for discussion—Sudbury as well as Kirkland Lake so we can include some of those other people from the north in our travels, so people from Kapuskasing and Ignace could be included, because Sudbury is a good location to travel in and out of and perhaps might facilitate it a little bit better. I will just put that forward as a point to be discussed.

The Chair: I see heads nodding here. What I intend to do, Mr Martin, is rotate through the caucuses. You are on the next round.

Mr Cousens: I was just thinking, maybe we could try North Bay and Kirkland Lake to give you two options in the north country. Then we have our four places.

The Chair: Mr Martin, you have the floor.

Mr Martin: Just a couple of comments so that we are not mincing words and people know where we are coming from. Certainly that was not my intention.

First of all, I think as politicians we need to be able to sort out those who come here from self-interest or who have conflict of interests, really, their own business aspirations versus the good of the people of Metro re their garbage problem and the good of the north re what it is willing to accept in the way of garbage from the south.

We in the north have been very strong about our position in this party. It was not just a decision of the minister to not ship garbage north. We told her, as people who represent most of the north in this Legislature, that we did not want Metro's garbage in northern Ontario. I think that by going to Kirkland Lake you are going to focus the discussion on that particular project and on that particular issue, and we have been very adamant about that.

If you want the perspective of northerners on this whole question of what Metro will do with its garbage, I suggest you go some place that is more central, that is going to reflect more adequately and more rationally the position of those of us who live and work and breathe and hope to live in northern Ontario for a long, long time in an environment that is unpolluted and that will provide industry for all of us. I think North Bay would present the same focusing of the discussion as Kirkland Lake would, because North Bay certainly stands to gain economically from that proposal as well. Sudbury, to my mind, presents a place where you would get a more rational, varying view of our position on this particular question.

Mr Cousens: I hear you, Mr Martin, and I guess when you talk about how caucus is involved in helping the minister come to a position—and your caucus has been influential in persuading Mrs Grier, the Minister of the Environment, not to consider a northern option, such as

Kirkland Lake, for a disposal site—you are no different from the way we work in our caucuses in trying to make sure certain things happen. That is the normal process here.

We are into a different process at this point when the committee resolves its hearings. When you are in opposition, which you were prior to September 6, there were many occasions when you would have had a different position from the government. What we are asking for, as the legitimate opposition, is that there be an opportunity for us to have a chance to look at that site. That is the site I have referred to. As the member from our party, I have never referred to any other northern sites, because I just did not want to have the war you would get into with some of those who might be an unwilling host, not unlike what Marmora was at one time. All you had to do was mention this and they knew what you were talking about. As a member of the opposition and as critic for Environment, I am saying I have had a lot of time, and certainly in Metro Toronto there has been a great deal of money invested in that as an option.

The answer is, sure it is to give attention to a site that has been considered. But I will tell you, we all know why we are going. In fact, if I may take it a step further—and I think you have been fair in coming back—we would not be having these public hearings had not the opposition been strong in its will to persuade the government to have public hearings. Otherwise, one of the bills that would have been passed for third reading and royal assent by December 19 would have been Bill 143.

1820

Quite candidly, when you had a chance for three weeks' hearings here and one week outside, it was to give opposition and yourselves a chance to present all sides of this bill. One of the key aspects of this bill, from our party's point of view, a very fundamental concern, is the decision by your Minister of the Environment and responsible for the greater Toronto area to exclude areas outside of the greater Toronto area for a landfill site. There is no area more identified in the minds of Metro and my caucus than Kirkland Lake. That is why I excluded any other place.

I am interested in going to Kingston and I am interested in going to Sarnia, and those are the names that were presented by other parties. But I am really anxious to have the chance to look at it, and I want to see the site. I want to look at it. I want to talk to the people. I want to get the feel of it. If it is a painful day for New Democrats, I happen to believe it will not be all that painful, because it turns out that in the town referendum it was 69%, so there is at least 31% within the community who think otherwise. There is always another side, so even in Kirkland Lake, knowing how this clerk of ours has a magic way of pulling things out, you are going to have both sides presented.

Come on, give us the break we are asking for as a legitimate—or illegitimate—third party.

The Chair: Could I suggest that there has been a proposal for a compromise put on the table by Mr O'Connor that has not been fully discussed or considered. I know you have made the presentation for North Bay.

Mr Cousins: No, I did not take any position.

The Chair: He did suggest as a compromise Sudbury and Kirkland Lake, as well as Kingston and Sarnia. You have not discussed that as an acceptable option, those four sites and whether that would satisfy your concerns.

Mr Martin: Being from the north, I would like to propose a motion. To be honest with you, looking at what has been proposed re this bill and our stance re garbage not coming to the north, I have a difficult time understanding why we are going there in the first place. But if we are going to go there, I suggest we go to communities that represent what is up there, that we have some large communities and some small communities and that we not focus the discussion on one particular project.

I put a motion that we go to Sudbury, a larger community, and that we go to Kapuskasing, a smaller community, to get their perspective on the issue of Metro and what it is trying to do with its garbage at this time.

Mr Cousins: You are making that motion?

Mr Martin: Yes, I am.

Mr Cousins: What the heck is it all about, then, Tony? I really do not see anything served, as it pertains to Bill 143, by the motion before this committee.

The Chair: We have a number of motions. We have the motions of the subcommittee; we have the recommendations that have been put forward. Could I suggest that we just start voting on them all and see if we can get a consensus for the four sites? Are we ready to do that?

Mr McClelland: No. Before we do, I will make one point. We understand what Mr Martin is saying. I think you are forgetting something, with respect, sir, that opposition has a legitimate role in the process that you and I and all members here are engaged in. As much as you may not appreciate that or want that to be the case, that is the case; if nothing else, in terms of fairness and respect for the role of opposition. You may find that hard to take, but that is the reality in this process.

Mrs Mathysen: I am really tired—

Mr McClelland: We are all very tired, Irene. You must, at some point, accept the fact that opposition, whether you like it or not, has a role, and you have to accommodate that role, at least a little, at least occasionally.

The request put by the third party, which I support, is a very reasonable request. It is one of four for the opposition. If you as a government, and you have the power to do it with your numbers, want to say that you are not prepared to accommodate one out of four, that you are not prepared to give that much in recognition of the legitimate role of opposition, then you are saying, out of hand, I believe, that ultimately you reject the validity of an opposition member as a critic, the third party as a critic, to take issue with your philosophy, whether we agree with it or not.

We may find that we agree with you, sir, at the end of the day. But to not allow that and not allow opposition to have the forum for full open discussion with the public of this province, to me is fundamentally contrary to everything I think, at the end of the day, you believe in. I want you to consider it in that context. You are saying to the

opposition, "We will not give you one out of four." I ask you how, in fairness, if nothing else, you can justify that position.

Mrs Mathysen: I would like to point out for the record that on this side there has been some give and take, there has been some compromise, and remind the honourable member opposite that they got the dates they requested. In view of that, I would suggest that characterizing the discussion as simply one-sided is probably not fair.

The Chair: I would like to suggest that we vote, as there does not seem to be consensus.

Mr Cousins: Rather than take it to the question, is there another way we can do it? Is this committee now saying, having tried to come up with agreement on Kingston and Sarnia, and there was general consensus that we move towards that, what does it take to—maybe we could have a recess for 15 minutes and have further discussion on this. I find this not a happy resolution.

The Chair: In the interest of seeing if you can accommodate, Mr Wiseman, Mr Cousins, Mr McClelland as the whips, would you like to take a few minutes to see if you can come up with an agreement?

Mr Wiseman: We have discussed this already. I think the compromise is that we would be prepared, as all committees are, to bring people from Kirkland Lake to Sudbury or Kapuskasing in order to discuss this as an issue. I think that fits well within the parameters of the discussion. Given that the Notre Mines headquarters in North Bay is just up the road, it would be a very central location for people to come to in Sudbury. I had the map open in subcommittee. I sensed that Sudbury or Kapuskasing, or both, would be a compromise to take into consideration. If my memory serves me right, it was more than just the Kirkland Lake area; it was that whole region. I think it would be served to go to Kapuskasing and Sudbury, so we could bring people from Kirkland Lake to discuss it.

Mr McClelland: I would want North Bay to certainly be considered. I will say this: At the end of the day, if you vote that way what you are saying is that you are giving opposition, on one hand, the right to public hearings, but on the other hand saying, "By the way, the place you want to have the public hearings we're not going to consider."

I want to be very clear, and I want this on the record. We negotiated through a very tough series of negotiations in the face of a closure motion, and fought, as Mr Cousins has said, for public hearings. You are making that a sham by saying, "We'll give you the public hearings, but we won't give it to you where you want it." It is not a light matter. To your colleague, I say it is something you have to understand, that you are setting a tone where you are saying to opposition, "We're sorry, we don't want you to participate and have your small piece of the action."

That is what it is. When you cut through all the rhetoric, you are saying, "We're giving you hearings, but you're not going to have them anywhere you want, when all is said and done," the one place the third party and the official opposition feel very strongly about.

Recognize that this is the tone you are setting for the out-of-town. I think it is absolutely unforgivable in terms of the whole process. You know full well that the negotiations for public hearings were based on the demands of opposition for those public hearings. You would not even have given them if it were not for opposition, and now you are saying to the opposition, "You're not going to have them where you want." I find that beyond belief, that you can sit there and do that without even a consideration of fairness and what is involved in that decision.

1830

Mr Martin: That is okay. I accept your position and your arguments. You put them very eloquently. Being from the north—I live and work up there—I am telling you that if you want a fair assessment of this particular batch of legislation and proposals you go to Sudbury and Kapuskasing and you will get it better there than you will in Kirkland Lake. You are not listening to me or accepting my experience or view, coming from northern Ontario, on this issue, so I throw the same thing back at you. We can go back and forth on this all night, if you like, the opposition versus those of us who live in the north, and where we go and the give and take in all of that. I am saying come to the north; that is an accommodation. But I am saying that when you come up there, listen to us who live up there, who tell you that you will get a better perspective on this whole thing if you come to Sudbury and Kapuskasing.

Mr Cousens: Is there compromise, possibly? Is there a chance the government would consider Sudbury and Kirkland Lake? I will come back to it. It was on the table at one point from across the way, and it is almost within the way of doing it. I appreciate very much the twin in the same suit as mine; it looks as if we went to the same sale. Mr McClelland's comments expressed very well the concerns I have as a member of the Conservative Party. We have members from the north. I have concerns about the north. Our leader is from Nipissing. Is there a chance that there is some possibility of Kirkland Lake and Sudbury?

Mr Wiseman: I would like to address some of the comments Mr McClelland made. I do not see this as being uncompromising, in that we as a committee have compromised on the time of the committee hearings and we have compromised on a number of issues with respect to presentations and presenters. We have made a number of commitments and changes on a whole host of things in this, so if you do not get Kirkland Lake it does not imply to me that we have been totally uncompromising.

I listened to my member from the north and I take what he has to say very seriously. He is bringing a perspective to this committee which, if I ignore it, is just another time that somebody from the south has ignored the wishes and the desires of the members from the north. It is going to be a pretty difficult day for me to turn around and ignore what my member from the north says. I would say at this point, with all due respect to the arguments that have been made, that I do not think a compromise is possible, given the very passionate views the member for Sault Ste Marie holds. He has changed my mind, okay? He has changed

my mind and I am going to vote the way he has requested that I vote.

Mr Cousens: Could I move that we have this referred to the House leaders and that the committee adjourn?

The Chair: I must say that I do not believe this matter is one which the House leaders would normally decide on, and that this matter can and should be decided by the committee. House leaders look after things like scheduling when committees cannot decide. They can determine what they will or will not permit on budgets, but there is no reason I can see why the House leaders should make a decision on location.

Mr McClelland: I want to say two things, if I might. First, to the comments made by Mr Martin, I accept them and I thank him for them. Again, I will simply say that if opposition wants to, in your opinion—forgive me if I misinterpret a value judgement—make the mistake of choosing the wrong location, surely that is a right opposition ought to have, to make that mistake, if that is what we do, given that it is the one place we wanted.

You have the numbers and ultimately you can control that, but bear in mind that is exactly what you are doing: You are dictating it. The reason I think it might be appropriate for House leaders is this, Madam Chair. This whole process was born out of response to a time allocation we were extracted from by way of negotiation through the offices of the House leaders. There was an awful lot of fuel put to that fire. It is evident that our position was that one of the things we wanted was public hearings and when we could travel, and there were some things that were understood about that. I think that Mr Cousens's motion, although unusual, is not entirely out of order.

The Chair: I have listened very carefully to the debate before the committee. I believe I have heard all of the debate and the arguments that have been put forward. I am going to rule that Mr Cousens's motion to refer to the House leaders is not one which should properly be sent to the House leaders, and that we should be voting at this time.

I am going to suggest a voting procedure which I hope will be acceptable to all the committee members, that is that we try, if we can, to begin by voting on four sites and go through that list; rather than voting on the sites individually, to look at them as a package. Is that acceptable to all members?

Mr Cousens: No, I do not have my other caucus members here. Can we recess until I have my caucus members here?

The Chair: Twenty minutes?

Mr Cousens: That is fine.

The Chair: I have a request for a 20-minute recess. At 7 pm we will be voting.

Mr Martin: Can I suggest, out of a need I have, that if we are going to recess we recess till 7:30?

The Chair: Is there any possibility that you could come to an agreement on location between now and 7:30?

Mr McClelland: There is always a possibility.

The Chair: Then it is agreed that we will recess until 3:30? Agreed.

The committee recessed at 1839.

934

Mr Hope: Madam Chair, some of us are supposed to be on duty right now, and they are calling for a quorum.

Mr Wiseman: I do not see any problem with item 6.

The Chair: Agreed? Agreed.

Mr Wiseman: I do not see any problem with item 7.

Mr Cousens: No, I am not prepared to discuss any further unless there is some movement, unless you voted on item 5 while I was out.

The Chair: No, we have not. I thought we might deal with those where there is agreement.

Mr Cousens: No, I would say at this point that I would be interested in knowing where we are really going. Was there any change in discussion? Did you get anywhere?

Interjection: The motion is on the floor.

The Chair: All right, on item 5, I would suggest we take the locations alphabetically, and the first four that get a majority are agreed to by the committee. Is that agreed? Kapuskasing is the first one on the list. I am suggesting we do them in alphabetical order.

Mr Cousens: Can we put Kirkland Lake on the list as well?

The Chair: It is on the list. The ones on the list are Kapuskasing, Kingston, Kirkland Lake, North Bay, Sarnia and Sudbury.

Mr Martin: I guess I am having some—we are going to choose the first four?

The Chair: No, what I am suggesting is that we take all of the locations that were suggested, that we vote on them in alphabetical order, and the first four that get a majority vote of the membership are the places we will go.

Mr Wiseman: Are we looking for three or are we looking for four?

The Chair: I understood we were looking for four. Am I incorrect?

Mr Wiseman: I have no problem with that.

The Chair: So we will go down them and wherever there is a majority, those will be the ones that are agreed to. Is that agreed? Ignace was suggested as well, just to add to the list. So the list, again, is Ignace, Kapuskasing, Kingston, Kirkland Lake, North Bay, Sarnia and Sudbury.

Mr Martin: With that, I would move a five-minute recess so we can decide among ourselves which four out of that we would prefer to go to.

Mr Cousens: All right, why not have a half-hour recess, then, Madam Chairman?

Interjection: No, no.

Mr Cousens: We can have a half-hour recess and consider it, because there may be a chance of some movement.

The Chair: They are ready to go. The whip has not requested a recess.

All those in favour of Ignace? There being no votes, Ignace is no longer on the list.

All those in favour of Kapuskasing? Five votes.

Mr Cousens: Is there going to be any debate?

The Chair: No; we are voting. All those in favour of Kapuskasing? Six. All those opposed?

Mr Cousens: I want to object. I very strongly oppose, and I would like to have it recorded.

The Chair: A recorded vote.

The committee divided on the question, which was agreed to on the following vote:

Ayes—6

Haeck, Hope, Martin, Mathysen, O'Connor, Wiseman.

Nays—2

Cousens, McClelland.

The Chair: The next location is Kingston. All those in favour of Kingston, please signify. A recorded vote.

The committee divided on the question, which was agreed to on the following vote:

Ayes—6

Haeck, Hope, Martin, Mathysen, O'Connor, Wiseman.

Nays—2

Cousens, McClelland.

The Chair: The next location is Kirkland Lake. All those in favour of Kirkland Lake? A recorded vote.

The committee divided on the question, which was negated on the following vote:

Ayes—2

Cousens, McClelland.

Nays—6

Haeck, Hope, Martin, Mathysen, O'Connor, Wiseman.

The Chair: The next location is North Bay. All those in favour of North Bay? A recorded vote.

The committee divided on the question, which was negated on the following vote:

Ayes—2

Cousens, McClelland.

Nays—6

Haeck, Hope, Martin, Mathysen, O'Connor, Wiseman.

1940

The Chair: The next location—

Mr Hope: Madam Chair, before you continue, have there been three selected already?

The Chair: We have selected Kapuskasing and Kingston only: two locations. The next location is Sarnia. All those in favour of Sarnia. A recorded vote.

The committee divided on the question, which was agreed to on the following vote:

Ayes—7

Haeck, Hope, McClelland, Martin, Mathysen, O'Connor, Wiseman.

Nays—1

Cousens.

Mr Cousens: This committee has really destroyed my sense of confidence that we are going to be capable of having worthwhile hearings. I strongly object to what has been done and the high-handed way in which the government is considering the role of the opposition.

The Chair: I call you to order. Thank you, Mr Cousens. We have one more location. We are voting on Sudbury.

The committee divided on the question, which was agreed to on the following vote:

Ayes—6

Haeck, Hope, Martin, Mathysen, O'Connor, Wiseman.

Nays—2

Cousens, McClelland.

The Chair: We have selected Kapuskasing, Kingston, Sarnia and Sudbury as the four locations. The clerk will be advertising to ensure those communities are made aware that the committee will be visiting. Members of the committee will be notified of the dates we will be in those locations.

The next item is 6. Any discussion on item 6? This is, "When the clerk is scheduling, deputants will be informed of the time." The subcommittee has suggested that they be asked to leave about half their time for questions from the committee.

Agreed to.

The Chair: Item 7 is: "that the Chair be authorized to attend to the budgetary needs." We have a budget that has been distributed and I would suggest that we approve the budget. For the additional advertising which was discussed at the committee, there are sufficient funds in our budget already to cover that additional advertising. Mr Cousens?

Mr Cousens: It was referenced by one of the members of the governing party that transportation expenses would be paid for people from Kirkland Lake who would want to come to Sudbury or Kapuskasing. Is that included in the budget?

The Chair: It is my understanding, Mr Wiseman, that you made those comments, although that is not included in the budget. Was it your intention to pay for people?

Mr Wiseman: Not mine personally, no.

Mr Cousens: I see that the budget reflects that magnanimous gesture.

Mr Wiseman: I think it is appropriate to, within reason. All committees have the funds to bring in people who have difficulty paying to come to the hearings. In terms of doing it, I thought that was something that was there.

The Chair: No, it is not the normal practice for the committee to pay travel expenses for deputants. If requests

are made, the committee can consider that, but these are usually requests in advance and decisions in advance, and there are no funds in the budget to pay for—the clerk advises me that we have a small amount available in our current budget. The clerk has told me that the normal practice is that where a request is made by a deputant, it is a decision of the subcommittee that usually will determine whether or not that happens.

Mr Wiseman: I would be very concerned that we not have this as an uncapped amount. I would need some direction in terms of cost to travel, what the mode of transportation would be and what kinds of costs we are looking at here before we go too far out on a limb in magnanimous gestures. I would like to know what we are talking about in terms of dollars.

The Chair: Perhaps the best thing for the committee would be if I asked the clerk to explain the normal procedure, and also perhaps what funds are available within the existing budget.

Clerk of the Committee: The normal practice with committees is a request submitted to the committee, and normally if there is someone who does not belong to an association and who needs assistance in travelling, they will do it. In this case, if you are going to specify those people from Kirkland Lake, I cannot give you any figures on how much you are going to need until you indicate how many people. There could be 20 people who respond from Kirkland Lake. Are you going to give it to them all, or are you going to give it to none of them, or are you going to give it to some of them? If you are going to give it to some of them, at \$600 or \$700 for one, depending on the air fare, we could be looking at \$6,000 or \$7,000, and right now I think there is about \$3,000 in the budget. I am not absolutely certain what the figure is.

Mr Cousens: Whoever said that before suggested that accommodation and transportation expenses would be paid for people who would be coming from Kirkland Lake to another location. That had to be part of the thinking of government members when they were voting on Sudbury or Kapuskasing or even Toronto.

May I suggest that the clerk include in the budget a figure not to exceed \$10,000 for transportation expenses for people coming to committee meetings. In the spirit of what was said earlier, when Kirkland Lake was excluded from the list in the discussion that was held at that time, it was made very clear by a government member, who I think was the whip, that such accommodation would be made in the course of helping them defray expenses.

People who are interested in this issue may not have the funds to pay those expenses. If they cannot it would be rather sad, based on the commitment that was made earlier, that they then are not able to attend. It certainly was the spirit that was conveyed by Mr Wiseman at the time.

Mr Hope: In the spirit of what is supposed to have been done, I am going to speak—and I do not speak for Mr Wiseman; I speak for myself. I am totally opposed to paying travel expenses for individuals to participate when we are going outside of Toronto. I can understand that if

hearings were solely in Toronto, we would provide an avenue for people.

There is also an opportunity for written submissions, as understand there is with most committees. There is still an opportunity to put forward written submissions on their concerns. If we start getting into escalated costs in not only dealing with northern Ontario, but southwestern Ontario—you are talking Sarnia. For instance in Windsor, about which I earlier raised concerns around advertising, there is a number of landfills that Toronto likes to put its garbage in. It would be extremely costly for some of those people to get transportation to Sarnia.

I understand where Mr Cousens is trying to play the issue a bit. I am opposed to allowance of transportation costs in and around the area. It is important that people have the access through written submission and also through verbal presentations.

I would just like to air my concerns. I will be voting against it if in the budget there is to be allowance for travel expenses.

Mr Martin: It was certainly not my intention, in proposing and supporting what I thought we did in the previous motions, to provide money specifically for people from Kirkland Lake to attend these hearings; although, having said that, it has always been my feeling that people from northern Ontario who have to travel long distances, who do not get to participate in the process of government as easily as those who live close to Queen's Park and can take transit, or whatever to various forms of consultation, should be in some way assisted to do that.

If it has been the habit of the government to support people who make submissions who really cannot, and can prove they cannot afford to come here on their own, then I certainly would be for assisting people who genuinely want to attend to make a contribution. If they do not feel it is adequate to do it in writing, then I think we should be looking at ways of trying to, in the spirit of democracy, get their input and have them participate. But to focus it specifically on one community rather than people across Ontario who may have an interest in this I think would be wrong. It would not be fair.

The Chair: Are we ready for the question?

1950

Mr Cousens: Someone opposite made a statement about assistance for people coming from Kirkland Lake. Who was it that said that? What was their intention at the time?

The Chair: You will have to check Hansard. We have no formal motion on the table right now that we can vote on regarding paying expenses. No motion was put.

Mr Wiseman: It is my understanding that Kapuskasing is about 60 miles from Kirkland Lake. The round trip would be 120 miles. If all 15 slots in Kapuskasing were taken, which I strongly—

The Chair: I am going to call order. There is no motion. Is there a motion that somebody is going to place? We have nothing to debate. There is no motion. We have the budget.

Mr Cousens: I move that expenses for people coming from Kirkland Lake who wish financial assistance, as per the suggestion made by Mr Wiseman, be covered by the committee up to a maximum dollar to be set by this committee.

We have the intent of that and then we can determine the dollar figure, so we will not get caught up in the dollar figure.

The Chair: We have a motion now that we can vote on. I think we have heard the debate. Is there anything further you want to add to that?

Ms Haeck: Just the simple comment that Mr Cousens's motion speaks only to people from Kirkland Lake.

Mr Cousens: That was the intent.

Ms Haeck: I think there is a much broader intent that we, as people representing Ontario, have to fulfil. If you only put in the proviso of Kirkland Lake, what happens to somebody in Thunder Bay, Ignace or parts of Rainy River? I really believe it is inappropriate to be that area-specific. We have a limited budget. I am not personally averse to assisting people, but it is looking at need and it is looking at anyone who applies.

The Chair: I think we have heard everything that has to be heard. Why do we not just vote on the motion that is on the floor? Are we ready for the vote?

Mr Wiseman: Except we do not have a dollar figure on this. What are we voting on exactly without the dollar figure in it?

Clerk of the Committee: Mr Cousens moved that persons requesting assistance for travel from Kirkland Lake specifically—I do not have the exact wording, but the intent was people from Kirkland Lake requesting travel costs up to an amount to be determined by the committee. There was no dollar put on it.

The Chair: We will have the exact wording from Hansard. If this motion passes then the committee would have to debate and agree on a dollar limit to be included in the budget right after this motion passes.

All those in favour of Mr Cousens's motion? Are you requesting a recorded vote?

Mr Cousens: Yes, I am.

The committee divided on Mr Cousens's motion, which was negated on the following vote:

Ayes—3

Cousens, O'Connor, McClelland.

Nays—4

Haeck, Martin, Mathysen, Wiseman.

The Chair: Mr Hope, you are not voting? You abstain.

Mr Cousens: Can I make a motion that says that up to \$5,000 be set aside for transportation assistance?

Interjections.

Mr Cousens: It is a different motion. Are you the Chair, Randolph? I am asking the Chair.

Mr Hope: I am just trying to assist the Chair. The motion is out of order. You are talking about the same allowance.

The Chair: I am going to rule that the motion is not significantly different from the motion that was previously placed. That matter has been dealt with and we will now move on to the next item of business before the committee.

Mr Cousens: May I have the floor?

The Chair: You may.

Mr Cousens: Thank you, Madam Chairman. I just want to put on the record that Mr Wiseman, in discussing this issue, led me to believe there would be financial assistance for people who want to come to the committee meeting. If my motion previously was restrictive by suggesting Kirkland Lake, I would like to suggest to the Chair another motion that would be a little more open-ended. Certainly Ms Haeck indicated that is why she voted against the motion.

Also, we had one other member who was not interested in voting on the issue possibly out of embarrassment because of the commitment he had earlier made, so he was going to try to sit on the fence and pretend that he had not said what he said. I would therefore like to make another motion that a transportation assistance fund be set up to assist people to come to the committee meeting, the figure to be determined.

The Chair: I point out to you, Mr Cousens, that there is a transportation fund in the existing budget of approximately \$3,000. That is the advice of the clerk. Therefore, your motion is out of order, as we already have that in the budget.

Mr Cousens: Will that be indicated in the announcements, that financial assistance will be available to those people who need it?

The Chair: It is not the normal practice of committee. However, if anyone inquires of the committee clerk, she will let the subcommittee know and it will then determine whether or not financial assistance will be provided. That is the normal course of practice.

Mr Cousens: Inasmuch as it has been presented in such a way as assisting people outside of the key areas where these presentations would be held, I move that it be included and reference be made to transportation assistance to people coming to the committee meetings.

The Chair: I am assuming you are referring to the ads that are going to appear on January 6.

Mr Cousens moves that in the ads on January 6, reference to a transportation fund be mentioned.

Mr Hope: Do you have seconders of this motion?

The Chair: You do not need seconders.

Mr Hope: You do not need seconders? Okay, just checking the rules. I speak against it and I will be voting against it because there is already advertisement out there and it adds inequity among the people of Ontario.

There may be people in the surrounding area who may be in financial hardship and may not be able to afford to come to the hearings, whether they be in Toronto or elsewhere, and I think it is most appropriate that if we do

something of this nature it is done at an earlier stage where there is a balance in the system. I will be voting against it.

Mr O'Connor: I believe that in other committees and in the standing committee on public accounts in the spring session last year, on one occasion a request was made for some assistance for somebody who had been requested to come down, and of course when she came there was some discussion within the committee as to the needs of this person and the expenses and a request was made that we assist her.

Hearing from some of my fellow committee members speaking today about making sure we address the needs of people who are making presentations, in fact we could be looking at people who would be travelling even a greater distance than the distance from Kirkland Lake to Kapuskasing.

Perhaps we should just follow the tradition and the past practice where if somebody comes before the committee and is requesting special assistance, at that time the committee deal with it. That might be the most appropriate way of dealing with it as part of the tradition that we have done in other committees that I have sat on in the past. Perhaps that is the most appropriate way of handling it in this instance as well.

The Chair: Mr Martin, you have the floor.

Mr Martin: In the spirit of my previous comments, I think it is only fair that we provide whatever assistance we can to folks who want to participate in the process. I find it interesting that it is the third party that is proposing it this time, that we actually do that and that we advertise it, in light of some of the criticism we have come under for spending of various sorts that we do in this time of great recession and restraint. But I am all for it. If you are going to have something out there that is available, then you have got to let people know that it is, and I have no problem with advertising it and letting people know. It is the fair thing to do and I will be supporting that.

The Chair: Are we ready for the vote on Mr Cousens's motion? All those in favour of Mr Cousens's motion? The motion is that the January 6 advertising include reference to a travel fund.

2000

Mr O'Connor: Could I just make one suggestion? If it is going to go out and address the needs right across the whole hearing process, then we could have to refer this matter back to the Board of Internal Economy, because we could be looking at a substantial sum of money. I think we had better consider that in voting on this.

Mr Martin: On a point of clarification, Madam Chair: It is my understanding that it was a cap of \$3,000.

The Chair: The amount that is available in the budget as of today is approximately \$3,000.

Mr Martin: And the process to this point at other times was, when it is gone, it is gone?

Clerk of the Committee: No, if you are advertising generally that it is available, I do not know what criteria you are going to make to determine who will get and who

will not get. There is not anything in this motion that determines one way or the other.

Mr Martin: What have you done in the past?

Clerk of the Committee: What I explained to you earlier. It was on request by people who were in particular need. It was not done for anyone who requested it; it was done, for the most part, for people who were in particular need of the funds.

Mr Martin: Would it not still apply to people, though, in particular need here? Was that your intent?

Clerk of the Committee: If you are advertising across the province, which is what this motion says, then you are going to have to establish some kind of criteria to pick and choose. You are advertising province-wide that you are going to make travel funds available. That is what this motion says.

Mr Martin: How did you determine particular need in the past?

Clerk of the Committee: Particular need was usually someone who did not belong to any organization and did not have any alternative funds available to them, but that is not what this motion says.

The Chair: Mr McClelland, you have the floor.

Mr McClelland: Briefly, I just want to recap for the record what I perceive. It is my perception of what has happened here.

The government has used its majority to rule out and to defeat the joint request of the opposition for hearings to be in a given location. In the debate on that motion it was indicated by a government member that in spirit, notwithstanding the fact that the government was going to defeat the one and only request that was put with respect to location—the government used its majority to defeat it—the government said, “We will accommodate,” and this is my understanding, “in terms of travel allowance.”

We are now debating that and it is now suddenly up for grabs whether or not it is going to in fact take place. I just wanted to recap that for the record. This government that talks about consultation and openness and willingness to listen to people used its majority to say no and now it is debating an issue of whether or not we will in fact assist people to come to the committee, having ruled out the locations.

The committee divided on Mr Cousens’s motion, which was negated on the following vote:

Ayes—3

Cousens, Martin, McClelland.

Nays—5

Haack, Hope, Mathysen, O’Connor, Wiseman.

The Chair: Number 6 we have already dealt with. I think we were on number 7. We have passed number 6. What I am proposing is that the budget, which has been circulated by the clerk to all members of the committee, actually be approved at this time so that it can be forwarded to the Board of Internal Economy. All those in favour of the budget as presented? Any opposed?

Mr McClelland: I would like a recorded vote.

The committee divided on the budget, which was agreed to on the following vote:

Ayes—6

Haack, Hope, Martin, Mathysen, O’Connor, Wiseman.

Nays—2

Cousens, McClelland.

The Chair: That will replace item 7 in the subcommittee’s report.

Item 8, that the research staff acquire legal interpretations and refer them for distribution to committee members. That was the recommendation of the subcommittee. All in favour? Any opposed?

Mr Cousens: And this will be done at what time?

The Chair: That is now being acquired and it will be distributed as soon as received and the research staff can make that available to all members of the committee. All those in favour? Any opposed? That is carried.

“That research staff prepare a summary of presentations to the committee in a format corresponding to the clauses of the bill, identifying comments and recommendations.” That is item 9. That was the recommendation of the subcommittee. The suggestion I would like to make is that we actually see if it is possible to have an interim report, as we did last time, and then a final report, rather than waiting and having it all at the end, if that is agreeable. I think that would be helpful for committee members. All those in favour of requesting as well an interim report? Any opposed? That is carried.

Shall we request also of research staff to try to have the summary completed on the Friday before the beginning of clause-by-clause, whenever that is to commence?

Interjection.

The Chair: We do not know when clause-by-clause is going to be, so if it is possible to have that at the latest by the Friday before, then I think members—yes, Mr Wiseman?

Mr Wiseman: The whole crux of the debate around when the committee is going to sit I believe revolved around having some analysis of the clause-by-clause in considerable time prior to the studying of clause-by-clause. If it comes in the Friday before clause-by-clause—

The Chair: The way it stands is this: If the House leaders agree with the committee’s request to be able to do clause-by-clause when the House returns, then we do not have a problem. If the House leaders do not agree to that request, then we have made the request of research for the Friday before. If that is not possible, it is not possible. I am just suggesting, if it is possible, that we request to have it by that time. Would you rather just leave it out? I do not want to complicate things. Why do we not just leave it out?

Mr Wiseman: Let’s leave it out, with the understanding that they will do the best they can to get it to us as early as possible.

The Chair: All right, agreed that the final report come as early as possible? Agreed.

For the committee today we have a request from Mrs Fawcett. It is notice to the committee that the subcommittee has to meet. This is to the Chair and the clerk of the standing committee on social development:

"For the purposes of standing order 123, I request that the subcommittee on committee business meet to consider a report to the committee on the following matter to be designated for consideration by the committee:

"Impact of the conversion of the Ontario scholarship assistance plan as a loans and grant program to a loans-only program and an examination of alternative student funding strategies such as the Ontario scholars award and the consequences of all possible changes in areas such as accessibility and affordability to post-secondary education, and the impact of these changes on economic growth, for the time period of 12 hours."

This is received formally by the committee, with a request that the subcommittee meet to discuss the 123 request. The next possible date for the subcommittee, I believe, is—

Clerk of the Committee: It is up to the subcommittee.

The Chair: Shall we leave that to the agreement of the whips to set a date at the call of the Chair for the subcommittee to meet? Agreed.

Ms Haeck: I just have a quick point of clarification to raise. Is the budget, as we have received it—

The Chair: No, we are dealing with this first and then we can go back to that question. Let's just deal with this. It is received and it will be up to the Chair to arrange with the whips for a subcommittee meeting on this matter—regular subcommittee or three whips? I need to know who is going to handle this. Whom should I call to find out about a subcommittee meeting? Is it Steve Owens or Jim Wiseman?

Interjection.

The Chair: You are going to be the whip?

Mr Martin: Yes, I am.

The Chair: All right. I will ask the clerk to be in touch with Mr Martin.

Mr McClelland: I would ask that you contact Mr Frank Miclash, please.

The Chair: Mr Miclash, and from your caucus who do you want contacted to find out who is the whip on this?

Mr Cousens: Mrs Witmer.

The Chair: Mrs Witmer. Thank you very much. Any other items? You had a question, Ms Haeck.

Ms Haeck: Yes. I was just wondering if this was an official document appended to this whole report. Under the terms of reference on the last page, is "the standing committee on social government" the appropriate title for this committee? It is just a small point and if it was an official document I thought it might be—

The Chair: It is a typo. Thank you for pointing it out to our otherwise perfect clerk. She appreciates it.

Interjection.

The Chair: We have an interjection from the Minister of Natural Resources. Thank you very much, Minister, for the assistance. I do not think Hansard picked up the comment, but that is okay.

Interjection: Merry Christmas to all—

The Chair: And to all—

Mr Wiseman: A good night.

Clerk of the Committee: Subcommittee members on the morning of January 14 at 9:30; I will let you know where. Do I have everybody's fax numbers?

The Chair: As noted, the subcommittee will be meeting on the morning of January 14 to complete the scheduling. The meeting stands adjourned.

The committee adjourned at 2013.

CONTENTS

Tuesday 17 December 1991

Waste Management Act, 1991, Bill 143 / Loi de 1991 sur la gestion des déchets, projet de loi 143	S-959
Committee report	S-959

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Clerk: Mellor, Lynn

Staff: Drummond, Alison, Research Officer, Legislative Research Service

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